# CITY OF BALTIMORE

# HEALTH DEPT.

# BUREAU OF

# VITAL STATISTICS

# DEATHS

# BEGINNING 1940

CITY HALL

BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

# DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF _____ BUREAU OF _____ _____ CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. _____ AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1090 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM 1 (11 58) RETAIN—PERM

# REQUEST FOR RETENTION PERIOD

To Records Management Officer
Room 408, City Hall, Baltimore, 2, Md

Authorization No: 345

Department: Health

Bureau: Vital Statistics

**Record Identification**

| 1 TITLE | 2 Form No if available | 3 Type—(cards paper etc ) |
|---|---|---|
| Certificate of Death | | Bound Book |

| 4 Dates | 5 Volume accumulated yearly | 6 Size of Record | 7 Number of copies made |
|---|---|---|---|
| | | Misc. | One (1) |

8 Authorization Requested (check only one (1) of the squares below)

A [ ] Establish retention period for records which are accumulating daily

B [ ] Dispose of present accumulation no additional accumulation anticipated

C [ ] Microfilm and destroy originals

D [X] Microfilm and retain originals for length of time indicated below

| 9 Recommended Retention Period a In Dept | b In Storage Center | c Total | 10 Equipment and space freed | 11 In your opinion does this record have any historical significance? |
|---|---|---|---|---|
| 12 yrs. | Micro. Perm. | 12 yrs. and Micro. Perm. | | YES NO X |

12 DESCRIPTION OF RECORD (describe accurately and show recommended retention period)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E Farber M.D. Title Commissioner of Health — Date 3/18/63

**Recommendation of Records Management Officer**

| 13 Recommended Retention Period a In Dept | b In Storage Center | c Total | 14 Disposal Method A | B | C |
|---|---|---|---|---|---|
| 12 yrs. | Microfilm Permanent | 12 yrs. and Microfilm Permanent | [ ] To be sold as scrap or waste paper | [X] To be Burned or shredded | [ ] Historical, (to be transferred to Dept of Legislative Reference ) |

REMARKS

C P Force — Records Management Officer — Date 3/19/63

**APPROVALS OF RECORDS DISPOSAL COMMITTEE**

KINDLY RETURN TO RECORDS MANAGEMENT OFFICER
ROOM 408 CITY HALL BALTIMORE 2, MD

1 APPROVED CITY AUDITOR

2 APPROVED CITY SOLICITOR

3 APPROVED CITY COMPTROLLER

4 APPROVED CITY TREASURER

5 APPROVED DIRECTOR DEPT OF PUBLIC WORKS

6 APPROVED DIRECTOR OF THE MUNICIPAL MUSEUM

7 APPROVED DIRECTOR, DEPT OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

8101 ✓ 44 W 678101

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Sandy Howard Howard

2. DATE OF DEATH: 9-10-49

PLACE OF DEATH: Baltimore City, Maryland 646 Dover

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dan 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 646 Dover St 7-07

Length of stay in Baltimore: ? Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year, last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Col | Widower | 10/3/1883 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - | Labor | Calvert Co. | U.S.A. |

13. FATHER'S NAME: William Howard

14. MOTHER'S MAIDEN NAME: Mary —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Emma Matthews ADDRESS: 655 Dover St

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchial Asthma | 2 mos |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) Chron. Cardio-renal vascular disease | years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 8 - 49, 19 , *to* Sept 10 - 49, *that I last saw the deceased alive on* Sept 10 - 49, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. N. Condon M. D. | 1524 Druid Hill Ave. | 9-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/14/49 | Eastern Chapel | Calvert Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 14 1949 | Huntington Williams, MD | Joseph A. Lively | 661 W. Barre St |

VS 150

1310

8102

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 974.0 G78102

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | Carl Hageman N-991 |
| 2. DATE OF DEATH | 9/12/49 |
| 3. PLACE OF DEATH: Baltimore City, Maryland | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore Md |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | South Balto General Hospital |
| D. STREET ADDRESS (If rural, give location) | 1240 Riverside Ave |
| Length of stay in Baltimore: Yrs. / Mos. / Days | 24 - 03 |
| 5. SEX | M |
| 6. COLOR OR RACE | W |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | Married |
| 8. DATE OF BIRTH | 8/24/1879 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min. | 70 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | ? |
| 10B. KIND OF BUSINESS OR INDUSTRY | American Sugar Refinery |
| 11. BIRTHPLACE (State or foreign country) | Germany (-UM) |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | ? Hageman |
| 14. MOTHER'S MAIDEN NAME | Unknown |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT / ADDRESS | Mrs. Carokine M. Burk, 1314 W. Balto. St. |

## CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation by strangulation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | |
|---|---|
| 19A. DATE OF OPERATION | - |
| 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES ☐ NO ☑ | |
| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | at home |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | 1240 Riverside Ave |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 9/12/49 about 11½ a.m. |
| 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | |
| 21F. HOW DID INJURY OCCUR? | Hung self in belt |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

| | |
|---|---|
| 23A. SIGNATURE | P. C. Talmadge M.D. |
| 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | ☑ |
| 23C. DATE SIGNED | 9/12/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial |
| 24B. DATE | 9/16/49 |
| 24C. NAME OF CEMETERY OR CREMATORY | St. Peters |
| 24D. LOCATION (City, town, or county) (State) | Balto. Md. |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 14 1949 |
| REGISTRAR'S SIGNATURE | Huntington Williams, M.D. |
| 25. FUNERAL DIRECTOR / ADDRESS | Wm. COOK, INC., 1217 St. Paul St. |

MEDICAL CERTIFICATION

VS 151

164a

78103

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

G78103

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Levi Travers

2. DATE OF DEATH: Sept. 12-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION: 921 W. Lexington (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived; if institution, residence before admission)
A. STATE
B. COUNTY
921 W. Lexington St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 18-01
D. STREET ADDRESS (If rural, give location): 921 W. Lexington St

Length of stay in Baltimore: 45 yrs (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Divorced | 1890 | 59 yrs | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Travers
14. MOTHER'S MAIDEN NAME: Mary J. Lane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Eva Speddeen ADDRESS: 1207 Edmondson Ave

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Stomach | |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) Metastasis | 6 mos. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/8, 1949 *to* 9/12, 1949 *that I last saw the deceased alive on* 9/12, 1949 *and that death occurred at* 4p *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Lacum M. D.
23B. ADDRESS: 600 N Calvert
23C. DATE SIGNED: 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 16-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James A Sharpe
ADDRESS: 638 N. Gilmor St

VS 460 (Rev.)

46B

3104 — G78104

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD DAUGHTREY
2. DATE OF DEATH: Sept 13, 1949

PLACE OF DEATH: Baltimore City, Maryland BALTO
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 23 Ridge Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Nov 5. 1884 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Store Clerk | Acme Food Store | Balto Md | |

13. FATHER'S NAME: Henry Daughtrey
14. MOTHER'S MAIDEN NAME: Martha Jonathan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | | 214-22-7477 | Florence M. Daughtrey | 23 Ridge Road |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) BILATERAL BRINCHO PNEUMONIA | |
| DUE TO | (B) PULMONARY EMPHYSEMA | |
| DUE TO | (C) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/1, 1949, *to* 9/13, 1949 *that I last saw the deceased alive on* 9/12, 1949, *and that death occurred at* 6:20 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Lee V. Shaw M. D. | 511 Agnes Hgts | 9/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 15. 1949 | Western | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 14 1949 | Huntington Williams M.D. | Mr & Mrs. John H. Teufel & Son | 5311 Edmondson Ave |

VS 159

MEDICINE CERTIFICATION

78105

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

G78105

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | HARRY THOMAS BUSSEY |
| 2. DATE OF DEATH | Sept. 11, 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2641 Pennsylvania Aves. |
| Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 2641 Pennsylvania Ave. 13 03 |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | divorced |
| 8. DATE OF BIRTH | Oct. 23, 1877 |
| 9. AGE (In years last birthday) | 71 yrs. |
| If Under 1 Year: Months / Days | |
| If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Pipe layer |
| 10B. KIND OF BUSINESS OR INDUSTRY | Self Empl Contractor |
| 11. BIRTHPLACE (State or foreign country) | Harford Co., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Thomas W. Bussey |
| 14. MOTHER'S MAIDEN NAME | Octavis Stonebraker |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | 219-01-1187A |
| 17. INFORMANT | Mrs. Ida Leeks |
| ADDRESS | 3523 Edmondson Ave. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 1 day |
| DUE TO | | |
| ANTECEDENT CAUSES | (B) Arteriosclerosis | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 6/27, 1949, *to* 9/11, 1949, *that I last saw the deceased alive on* 9/11, 1949, *and that death occurred at* 2 p. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Edmund S. Haering, M. D. | |
| 23B. ADDRESS | 1847 N. Howard St | |
| 23C. DATE SIGNED | 9/11/49 | |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 9/15/49 | Loudon Park Cem. | Balto., Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS | |
| SEP 14 1949 | [illegible] | WM. J. TICKNER & SONS | Balto., Md. | |

VS 150

83a

78106

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

G78106 Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | BESSIE BROWN BRADSHAW |
| 2. DATE OF DEATH | Sept. 13, 1949 |
| 3. PLACE OF DEATH: Baltimore City, Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 5731 Rock Spring Rd. |
| Length of stay in Baltimore | 5½ yrs. (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 5731 Rock Spring Rd. 7-15 |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widow |
| 8. DATE OF BIRTH | Dec. 2, 1877 |
| 9. AGE (In years last birthday) | 71 |
| If Under 1 Year Months Days | |
| If Under 24 Hours Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Princess Anne, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Archie Humphrey |
| 14. MOTHER'S MAIDEN NAME | Sarah McIntire |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO | |
| 17. INFORMANT ADDRESS | Mrs. Betty Knapp - 5731 Rock Spring Rd. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemmorhage | 4 days. |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized Arteriosclerosis | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 9-9-, 1949 *to* 9-13, 1949 *that I last saw the deceased alive on* 9-13, 1949, *and that death occurred at* 4:35 A *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE M. D. | Nathan Wolf | |
| 23B. ADDRESS | 4117 Belvieu Ave -15- | |
| 23C. DATE SIGNED | 9-13-49. | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 9/15/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Western Cem. | |
| 24D. LOCATION (City, town, or county) (State) | Balto., Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 14 1949 | |
| REGISTRAR'S SIGNATURE | Evington Williams, MD | |
| 25. FUNERAL DIRECTOR ADDRESS | WM. J. TICKNER & SONS Balto., Md. | |

VS 150

83a

3107 G78107

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-0 1 Registered No.

STH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | RALPH NIES MOMBERGER |
| 2. DATE OF DEATH | Sept. 13, 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 611 N. Kenwood Ave. |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A STATE | Md. |
| B COUNTY | |
| C CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 611 N. Kenwood Ave. |
| Length of stay in Baltimore (Yrs. Mos. Days) | life |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | May 9, 1909 |
| 9. AGE (In years last birthday) | 40 yrs. |
| If Under 1 Year: Months / Days | |
| If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Accountant |
| 10B. KIND OF BUSINESS OR INDUSTRY | Oil |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | John Frederick Momberger |
| 14. MOTHER'S MAIDEN NAME | Anna M. Nies |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO | 214-01-4300 |
| 17. INFORMANT | Mrs. Mary E. Momberger |
| ADDRESS | 611 N. Kenwood Ave |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute Coronary Occlusion | 12 Days |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A), STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Aug. 31, 1949, *to* Sept. 12, 1949, *that I last saw the deceased alive on* Sept. 12, 1949, *and that death occurred at* 7 a m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Wm J Johnston M. D. | 23B. ADDRESS 701 N. Kenwood Ave. |
| 23C. DATE SIGNED | Sept 14-49 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 24B. DATE 9/16/49 |
| 24C. NAME OF CEMETERY OR CREMATORY | Woodlawn | 24D. LOCATION (City, town, or county) (State) Woodlawn Md. |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 14 1949 | REGISTRAR'S SIGNATURE Tunstall Williams, M.D. |
| 25. FUNERAL DIRECTOR | WM. J. TICKNER & SONS | ADDRESS Balto., Md. |

VS 150

94a

3108 G78108

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edna Anna Lippert

2. DATE OF DEATH: Sept. 13 1949

PLACE OF DEATH: Baltimore City, Maryland Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3203 Normount Ave

Length of stay in Baltimore: life Yrs. Mos. Days

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 10-14-89
9. AGE (In years last birthday): 59
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Md (Baltimore)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm A. Shelley
14. MOTHER'S MAIDEN NAME: Mary Tuttle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Laennec's cirrhosis - Probe hypotension
DUE TO
(B) Vasomotor collapse
DUE TO
(C) Excessive blood loss

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9.13.49
19B. MAJOR FINDINGS OF OPERATION: Cirrhotic liver - splenomegaly
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/7, 1949 *to* 9/13, 1949 *that I last saw the deceased alive on* 9/13, 1949 *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. J. McBeth M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 9.15.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/16/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

124a

CERTIFICATE CORRECTED 9-22-49

109

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78109

RTH NO.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) | MAUDE ETTIE HARE |
| 2. DATE OF DEATH | 13 Sept. 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 503 W. 28th St. |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| Length of stay in Baltimore | 46 yrs Mos. Days |
| D. STREET ADDRESS (If rural, give location) | 503 W. 28th St. 1207 |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Nov. 12, 1883 |
| 9. AGE (In years last birthday) | 65 yrs. |
| If under 1 Year: Months, Days | |
| If under 24 Hours: Hours, Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | home |
| 11. BIRTHPLACE (State or foreign country) | Bentley Springs, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Leonard Harris |
| 14. MOTHER'S MAIDEN NAME | Mary F. Standiford |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT | Mr. O. P. Hare |
| ADDRESS | 503 W. 28th St. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia; etc. It means the disease, injury or complication which caused death.) | (A) Rheumatic Heart Disease | ?50 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Nov, 1948 *to* 13 Sept, 1949, *that I last saw the deceased alive on* 11 Sept, 1949, *and that death occurred at* 3:30 p m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Robert E. Mason M.D. | 23B. ADDRESS: 9 East Chase St. |
| 23C. DATE SIGNED | 13 Sept '49 | |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| Burial | 9/16/49 | New Market Cem. | Maryland Line, Md. | |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| SEP 14 19 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150.

952

78110

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

150.0 Registered No. G78110

STH NO.

NAME OF DECEASED (Type or Print): ANN LUX BUCHANAN SHREVE

2. DATE OF DEATH: SEPT. 13, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 102 OAKDALE RD.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTO.

Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): SAME

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W | WIDOWED | AUG. 3 1865 | 84 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JAMES HOLLIS BUCHANAN

14. MOTHER'S MAIDEN NAME: HENRIETTA GITTINGS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: C.A.B. SHREVE ADDRESS: 104 W. UNIV. PKWY

## CAUSE OF DEATH

16. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerosis — INTERVAL BETWEEN ONSET AND DEATH: ? yrs.

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B)

DUE TO

(C)

II

**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Nov. 20, 1943 *to* Sept. 19, 1949 *that I last saw the deceased alive on* 6/15/ 1949 *and that death occurred at* 5-H m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathan B. Freeman M. D. | 1041 St. Paul St | 9/13/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9-15-1949 | SHERWOOD CEM. | COCKYESVILLE MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 14 1949 | Huntington Williams, MD | H.W. JENKINS & SONS CO. | YORK RD. |

VS 150

97

78111

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

Registered No. G78111

RTH NO.

1. NAME OF DECEASED (Type or Print): Roscoe Joseph Kiel

2. DATE OF DEATH: September 12 '49

PLACE OF DEATH: Baltimore City, Maryland — Baltimore Md

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 514 E 35th Street

Length of stay in Baltimore: 71 Yrs. ~~Mos. Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-03
D. STREET ADDRESS (If rural, give location): 514 E. 35th Street.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 2. 1877 | 71 | 9 | |

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired): Army Engineer (Retired)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George a. Kiel
14. MOTHER'S MAIDEN NAME: Catherine Ruth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs. Roscoe J. Kiel wife ADDRESS:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Spinal apoplexy | 19 days. |
| DUE TO (B) | Arteri-sclerosis | Unkn |
| DUE TO (C) | Chronic nephritis. | Unkn |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 24, 1949, to Sept. 12, 1949, *that I last saw the deceased alive on* Sept. 12, 1949 *and that death occurred at* 2:30 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles L. Taggett M. D.
23B. ADDRESS: 3812 Greenmount Ave.
23C. DATE SIGNED: Sept. 12 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 15/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Lorraine Cem
24D. LOCATION (City, town, or county) (State): Woodlawn Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Henry N. Jenkins Sons Co
ADDRESS: 4901 York Rd

VS 150 . . .

131a

3112 G78112

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA FANGMANN
2. DATE OF DEATH: SEPT-13-49

PLACE OF DEATH: Baltimore City, Maryland 1210 LIGHT ST.
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1210 LIGHT ST
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
BALTIMORE MD
D. STREET ADDRESS (If rural, give location)
1210 LIGHT ST 23-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEM. | WHITE | WIDOW | APRIL-14-1864 | 85 | 4 | 30 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: ELIZABETH FLERLAGE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MRS ALBERT ZAPF ADDRESS: 1210 LIGHT ST

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary occlusion | one week |
| DUE TO (B) | arteriosclerosis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Senility | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Myocarditis | |

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/7/49, 19__ *to* 9/13, 1949, *that I last saw the deceased alive on* 9/13, 1949, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Isaac Miller M.D. M. D.
23B. ADDRESS: 122 E Chase St
23C. DATE SIGNED: 9/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: SEPT 17-49
24C. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEM
24D. LOCATION (City, town, or county) (State): N. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bernard C Starke ADDRESS: 121 E WEST ST.

VS 150

93D

8113 · BALTIMORE CITY HEALTH DEPARTMENT · G78113

# CERTIFICATE OF DEATH

Registered No. 4 53

BIRTH NO.

NAME OF DECEASED (Type or Print): Mrs Anita Covill

2. DATE OF DEATH: 9-13-49

PLACE OF DEATH: Baltimore City, Maryland — St. Agnes Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mrs Anita Covill

Length of stay in Baltimore: ? Yrs. ? Mos. ? Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
- a. STATE: Md.
- b. COUNTY: Baltimore
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — #27
- d. STREET ADDRESS (If rural, give location): 5401 E. Drive Halethorpe

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | march 16 188? | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Germany | — |

13. FATHER'S NAME: Henry Steinhagen

14. MOTHER'S MAIDEN NAME: Engel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | ? | Mrs Raymond Strauss | 5491 E Drive, |

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arteriosclerotic Hypertension | |
| DUE TO (B) | Cardiovascular Renal Disease | |
| DUE TO (C) | | |
| II | Obesity, marked | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/11, 1949, *to* 9/13, 1949, *that I last saw the deceased alive on* 9/12, 1949, *and that death occurred at* 12:35 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert J. Lerches M. D. | St. Agnes Hospital | 9/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/16/49. | Loudon Pk. | 3801 Frederick Rd. Balto. 29. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 15 1949 | Huntington Williams, M.D. | Harry H. Leitzke | 4101 Edmondson Ave (931) |

3114

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1/3

G78114 Registered No.

RTH NO.

1. NAME OF DECEASED (Type or Print) Chiara Clara La Fortezza

2. DATE OF DEATH 9-11-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Sq Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balt.
D. STREET ADDRESS (If rural, give location) 1020 Lombard 3-0

Length of stay in Baltimore 36 yrs (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Italy | |

13. FATHER'S NAME Joe Terramei

14. MOTHER'S MAIDEN NAME Anna Schiaroni

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs Toney Ross ADDRESS 1020 E Lombard St

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive C.V Disease | yrs. |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Diabetes mellitus | yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-11, 1949, *to* 9-11, 1949, *that I last saw the deceased alive on* 9-11, 1949, *and that death occurred at* 8.45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A.J. Laham M.D. | Franklin Sq. Hosp. | 9-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 15, 1949 | Holy Redeemer Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Sol Levinson & Bros | 1126 |

VS 150

61

78115 BALTIMORE CITY HEALTH DEPARTMENT G78115

# CERTIFICATE OF DEATH

Registered No. 33

BTH NO.

NAME OF DECEASED (Type or Print): MINNIE KIRSCH

2. DATE OF DEATH: 9-14-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3901 Forest Park Ave 15-09

Length of stay in Baltimore: 55 yrs (Yrs. / Mos. / Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Dec 15, 1874 | 74 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Unkown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Laurice Kirsch
ADDRESS: 3901 Forest Park Ave

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral thrombosis | 3 days |
| DUE TO (B) | Cerebral arteriosclerosis | Years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Myocardial fibrosis, | Years |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-6 1949 *to* 9-14, 1949, *that I last saw the deceased alive on* 9-14, 1949 *and that death occurred at* 5 9 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Henry Nagel M. D.
23B. ADDRESS: Levindale Home
23C. DATE SIGNED: 9-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 14, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Washington Rd
24D. LOCATION (City, town, or county) (State): Cem Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

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3116

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4700 G78116 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rachel L. Bennett
2. DATE OF DEATH: 9-12-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 212 Myrtle Ave

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 212 Myrtle Ave 4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | W | Jan. 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Balto. Md. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | None | Charles Bennett | 212 Myrtle Ave |

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO [redacted] Disease

(B)

DUE TO Malnutrition

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1/9/49 *to* 9/12/49, *that I last saw the deceased alive on* 9/11/49, *and that death occurred at* 5:00 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 953 Carlton | 9/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| B | 9-15-49 | Mt. Auburn | Balto. City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Samuel W. Sullivan Jr | 937 1011 N. Arlington Ave |

VS 150

8117 — G78117

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 — Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Watkins

2. DATE OF DEATH: Sept. 12, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: 15 ✓
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1651 N. Fulton Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1651 N. Fulton Ave

Length of stay in Baltimore: 19 yrs. (Yrs. / Mos. / Days)

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: July 7 1899
9. AGE (In years last birthday): 52 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Farmville Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander Vaughn
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rosa Wilson — ADDRESS: 228 N. Carey St

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — (Interval between onset and death): 9.11.49

DUE TO

(B) Hypertensive Cardiovascular Disease — 1934 +

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Squamous cell Carcinoma - vulva — 1948

19A. DATE OF OPERATION: 5.25.48
19B. MAJOR FINDINGS OF OPERATION: uterine Fibroid - carcinoma cerv. -
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12.3.1934, 19__, to 9.12.49, 19__, that I last saw the deceased alive on 9.12.1949 and that death occurred at 3P m., from the causes and on the date stated above.

23A. SIGNATURE: James M. Pair, M. D.
23B. ADDRESS: 400 N. Carrollton Ave
23C. DATE SIGNED: 9.14.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-15-1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams — ADDRESS: 922 N. Schroeder St.

VS 150

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3118 ✓ X 8 33 G78118

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Jessie Maston (MASTON) Jessie Lillian

2. DATE OF DEATH: 9-13-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Salisbury
D. STREET ADDRESS (If rural, give location): 1109 W. Main St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | M | Dec. 10, 1894 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wife
10B. KIND OF BUSINESS OR INDUSTRY: Telephone Operator
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel I. Roop
14. MOTHER'S MAIDEN NAME: Katura Wheatley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Helen W. Roop, Detroit, Mich. — ADDRESS

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Encephalitis ? Carcinoma
DUE TO atrophy
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus - Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1 19 49 *to* 9-13 19 49 *that I last saw the deceased alive on* 9-13 19 49 *and that death occurred at* 5 30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. G. Smith Jr. M.D. M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 9-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 9/14/49
24C. NAME OF CEMETERY OR CREMATORY: Westminster
24D. LOCATION (City, town, or county) (State): Philadelphia, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

61

1119 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78119 — Registered No.

1. NAME OF DECEASED (Type or Print): HOWARD YOUNG CROMWELL

2. DATE OF DEATH: Sept. 13, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1521 Carswell Street

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1521 Carswell Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Jan. 9, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | B & O R.R. | Baltimore, Md. | USA |

13. FATHER'S NAME: Harry Cromwell

14. MOTHER'S MAIDEN NAME: Louisa Deihl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 705-04-2469

17. INFORMANT: 1521 Carswell St. 13 — Mrs. Anna K. Cromwell

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* Sept 13, 1949, *that I last saw the deceased alive on* Sept 12, 1949, *and that death occurred at* 2 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2700 Hyde Park | Sept 13 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 9/16/49 | Druid Ridge Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| SEP 14 1949 | Huntington Williams, MD | HENRY SANDER & SONS, INC. |

VS 150, ... [illegible] BALTIMORE - 13, MD. 937

G78120 ✓ G78120

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 420.0

BTH NO.

1. NAME OF DECEASED (Type or Print): John Andrew Dunn

2. DATE OF DEATH: 9-13-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21201
d. STREET ADDRESS (If rural, give location): 4018 Chesmont Avenue

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct 6-1892
9. AGE (In years last birthday): 56 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Lilly Tulip Cup Corp
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William H. Dunn
14. MOTHER'S MAIDEN NAME: Georgia E. Duncan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary S. Dunn — ADDRESS: 4018 Chesmont

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

(B) Arteriosclerotic Heart Disease ?

DUE TO

(C) Diabetes mellitus ? — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: azotemia, peripheral shock

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13 1949 to 9-13 1949, *that I last saw the deceased alive on* 9-13 1949 *and that death occurred at* 8:37 pm *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Cadle
23B. ADDRESS: Md. Gen'l Hospital
23C. DATE SIGNED: 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-17-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Edgar Poultney, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck — ADDRESS: 5305 Harford Rd.

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Dr. Sawyer
G78121

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78121 Registered No. 1920

TH NO.

NAME OF DECEASED (Type or Print): M. Dora Brumfield

2. DATE OF DEATH: Sept. 13, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5007 Arabia Avenue

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5007 Arabia Avenue 27-03

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | white | single | Oct. 25, 1857 | 91 | | |

| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at Home | | Port Deposit, Md. | |

13. FATHER'S NAME: George W. Brumfield

14. MOTHER'S MAIDEN NAME: Caroline Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Mary Mc Cullough ADDRESS: 5007 Arabia

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Heart Disease | 2 yrs. |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized Arteriosclerosis | 10 yrs. |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 1 1945 *to* Sept 13, 1949 *that I last saw the deceased alive on* Sept 13, 1949 *and that death occurred at* 5.55 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George Sawyer M. D. | 4808 Harford Rd. | 9/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-15-49 Wil. | Mt. Olivet | Baltimore, Md. |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 14 1949 | | Leonard J. Ruck | 5305 Harford Road. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH JANE WORLEY

2. DATE OF DEATH: Sept. 13, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3808 Penhurst Ave.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Kansas
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Holton
D. STREET ADDRESS (If rural, give location): 904 Ohio Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: June 30, 1849
9. AGE (In years last birthday): 100 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Peter Hollenbeck
14. MOTHER'S MAIDEN NAME: Missouri Carroll
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Grace B. Dague ADDRESS: 3808 Penhurst Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral arterio-sclerosis
Cerebral emboles (?)

DUE TO

(B) Two fractures right arm - April 49
Fracture right hip June 49

DUE TO

(C) mentally disoriented for years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

CERTIFICATION APPROVED BY
H. H. Hansbra M. D.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: no
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City give exact location): 3808 Penhurst Ave., Balto. Md. 15-16
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Apr. 22, 1949 ? m. / June 24, 1949
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? 1st Tripped over rug & fell to floor
2nd Rolled off of sofa to floor

22. I hereby certify that I attended the deceased from April 22, 1949 to Sept 13, 1949 that I last saw the deceased alive on 9/13/49 19___, and that death occurred at 4.45 P. m., from the causes and on the date stated above.

23A. SIGNATURE: H. W. Hansbra M. D.
23B. ADDRESS: 5701 Forest Park Ave
23C. DATE SIGNED: 9/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 9/14/49
24C. NAME OF CEMETERY OR CREMATORY: Larkinburg Cem.
24D. LOCATION (City, town, or county) (State): Kansas

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Lennington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

RTH NO.

NAME OF DECEASED (Type or Print): Alpha Wilson

2. DATE OF DEATH: 8-28-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 147 S. Linwood Ave. -24

Length of stay in Baltimore: 1 yr. (Yrs. / Mos. / Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| | White | Wid. | Sept, 12, 1867 | 81 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Peyton

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS:

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive cardiac vascular disease | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-7-49, 19__, *to* Aug. 28, 1949, *that I last saw the deceased alive on* Aug. 28, 19 49, *and that death occurred at* 10.35 AM *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Cozen M. D.

23B. ADDRESS: 4940 Easthern Ave.

23C. DATE SIGNED: 9-13-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried

24B. DATE: 9/14/49

24C. NAME OF CEMETERY OR CREMATORY: Laurel Fort

24D. LOCATION (City, town, or county) (State): Fernwood Free Rd

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. J. Fahey & Sons ADDRESS: 1218 Light St

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G78124

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 903.5 G78124 Registered No.

RTH NO.

NAME OF DECEASED (Type or Print): Martin Peterson

2. DATE OF DEATH: 9-12-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 221 Duncan Alley

Length of stay in Baltimore: Life (Yrs. Mon. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Widowed | May 10- 1878 | 71 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Peterson
14. MOTHER'S MAIDEN NAME: Annie Debelions or Debelious

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarct (old) with aneurysm formation

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

CERTIFICATION APPROVED BY
R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fracture neck of left femur

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9-2-1949
19B. MAJOR FINDINGS OF OPERATION: Fracture neck of left femur
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): In an alley
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Fell in an alley (rear of 221 Duncan Al)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Aug. 30-1949 m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell to the ground

22. *I hereby certify that I attended the deceased from* 8-31- , 19 49 *to* 9-12- , 19 49 *that I last saw the deceased alive on* 9-12- , 1949 , *and that death occurred at* 8.50P *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 9/15/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. CARMEL
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WILLY & LEILER INC.
ADDRESS: BALTO.

VS 150 Medical Certificate approved by the Medical Examiner

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G78125

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78125 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) **Mollye Stern .**

2. DATE OF DEATH **Sept.15th.1949.**

PLACE OF DEATH: **Baltimore City, Maryland** **Balto.Md.** 7

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
**5806 Narcissus Ave.Balto.Md.**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) **5806 Narcissus Ave.** 27-19

Length of stay in Baltimore **Lifetime,** Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| **Female** | **White** | **Married** | **About** | **45years.** | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME **Jacob Sandler.**

14. MOTHER'S MAIDEN NAME **Vera Hoffman**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | **Melvin F.Stern.** | |

## CAUSE OF DEATH

18. I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Rheumatic C-V- Disease** — INTERVAL BETWEEN ONSET AND DEATH: **about unknown**

DUE TO

(B)

DUE TO

(C)

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* **March 6** *, 19*49 *to* **Sept.13** *, 19*49*, that I last saw the deceased alive on* **Sept.13** *, 19*49 *and that death occurred at* **5P.** *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **Paul E. Carlson MD** M. D. | **242 South Pul** | **9/14/49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Sept.15th./49.** | **Balto.Hebrew** | **Balto.Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 14 1949 | [illegible] | **N. Van Lindham & Son** | **1902 Eutaw Pl.** |

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G78126

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78126 Registered No. 163

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sr. Mary Immaculata Dillon

2. DATE OF DEATH: Sept 13-49

PLACE OF DEATH: Baltimore City, Maryland 4701 N Charles St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Notre Dame of Md

Length of stay in Baltimore: Yrs. 27 Mos. 11 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Notre Dame Convent
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-11
D. STREET ADDRESS (If rural, give location) 4701 N Charles St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec, 1873
9. AGE (In years last birthday): 75 76
If Under 1 Year: Months 11 Days 11
If Under 24 Hours: Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10a. KIND OF BUSINESS OR INDUSTRY: Notre Dame
11. BIRTHPLACE (State or foreign country): Hagerstown Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Dillon
14. MOTHER'S MAIDEN NAME: Martha McCallion

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Sr M Peter Fournier ADDRESS: 4701 Charles St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO —

(B) —

DUE TO —

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1949, *to* Sept 13, 1949, *that I last saw the deceased alive on* Sept 13, 1949, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: J W Lockwood M. D.
23B. ADDRESS: 1129 St Paul St
23C. DATE SIGNED: 9/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 15/49
24C. NAME OF CEMETERY OR CREMATORY: Notre Dame Charles St
24D. LOCATION (City, town, or county) (State): Homeland Ave. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. W. Frisk Son & Mc Nulty ADDRESS

VS 150

47D

3127 ✓ X

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

180 Registered No. 078127

STH NO.

NAME OF DECEASED (Type or Print): STEPHEN Willie

2. DATE OF DEATH: 13 Sep 49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Pr. Geo.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Laurel, Maryland
D. STREET ADDRESS (If rural, give location): —

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | child | 9-24-46 | 3 | | | | |

| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Linwood Willie

14. MOTHER'S MAIDEN NAME: Rosalie Brown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | — | | |

## 18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Wilms tumor — INTERVAL BETWEEN ONSET AND DEATH: 2-3 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-6 19—, *to* 9-13 1949, *that I last saw the deceased alive on* 9-13 1949, *and that death occurred at* 11:50 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E J Broaddus M. D. | University Hospital | 9-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 19/49 | Ivy Hill | Laurel Md |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Hampton Williams M.D. | W. Neill Donaldson | |

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52a

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 16 [illegible]

STH NO. 16 C 49-19623

1. NAME OF DECEASED (Type or Print): INFANT Boy Morgart

2. DATE OF DEATH: 9/13/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.

Length of stay in Baltimore: 40hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-41
D. STREET ADDRESS (If rural, give location): 65 OAKLEE VILLAGE

5. SEX: male
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9-11-49
9. AGE (In years last birthday) | If Under 1 Year: Months | Days: 1 | If Under 24 Hours: Hours: 16 | Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Paul J Morgart
14. MOTHER'S MAIDEN NAME: Geraldine Moulton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No — None
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Paul D. Morgart ADDRESS: 65 Oaklee Villa

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-11 1949 to 9-13 1949, *that I last saw the deceased alive on* 9-13 1949 *and that death occurred at* 11:25A *m., from the causes and on the date stated above.*

23A. SIGNATURE: James L Gray M. D.
23B. ADDRESS: West Baltimore Gen. Hosp.
23C. DATE SIGNED: 9-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-17-49
24C. NAME OF CEMETERY OR CREMATORY: Memorial Cemetery
24D. LOCATION (City, town, or county) (State): Oklahoma City, OKLA.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949
REGISTRAR: [illegible]
25. FUNERAL DIRECTOR: Geo. L. Schwab
ADDRESS: 101 Frederick Ave

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Geraldine Morgart { GERALDINE MORGART
2. DATE OF DEATH: 9/13/49
3. PLACE OF DEATH: Baltimore City, Maryland — W. Balto. Co. Hosp
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: Md. B. COUNTY: Balto Cty
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 25-41
   D. STREET ADDRESS (If rural, give location): 55 Oakleigh Village
   Length of stay in Baltimore: — Yrs. 7 Mos. YRS. Days
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): W. Balto. Co. Hosp
6. SEX: F
7. COLOR OR RACE: W
8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
9. DATE OF BIRTH: Sept. 5, 1916
10. AGE (In years last birthday): 33 — If Under 1 Year: Months —, Days 5; If Under 24 Hours: Hours, Min.
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
12. KIND OF BUSINESS OR INDUSTRY:
13. BIRTHPLACE (State or foreign country): Tennessee
14. CITIZEN OF WHAT COUNTRY: Yes
15. FATHER'S NAME: Samuel Houlton
16. MOTHER'S MAIDEN NAME: Bessie ~~Houlton~~ Hudston
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No — NONE
18. SOCIAL SECURITY NO.: NONE
19. INFORMANT: PAUL D. MORGART — ADDRESS: 55 OAKLEIGH VILLAGE

### CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Respiratory Failure | 9/2 |
| DUE TO | | |
| (B) | Severe Fulminating Pneumonia | to |
| DUE TO | | |
| (C) | Pregnancy | 9/13 |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/9, 1949 *to* 9/13, 1949 *that I last saw the deceased alive on* 9/13, 1949 *and that death occurred at* 12:20 A.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: W. Balto. Co. Hospital
23C. DATE SIGNED: 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-17-49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
24D. LOCATION (City, town, or county) (State): Oklahoma City, Okla.
ADDRESS
DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 19[illegible]
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: George L. Schwab 2101 Frederick Ave

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 20. G78130 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Andrew S. Ohrin (OHRIN) 2. DATE OF DEATH Sept. 12, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 4011 Granite Av

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore 1 Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Honey Brooke
D. STREET ADDRESS (If rural, give location) Honey Brooke

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 13 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | Coal Mining | Pa. | U. S. |

13. FATHER'S NAME Andrew Ohrin

14. MOTHER'S MAIDEN NAME Emma Bretzler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 166-05-3415 | Charles Ohrin | 4011 Granite Av |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Arterio Sclerosis

DUE TO

(C) Coronary Occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-5 X, 19 49, *to* 9-12 19 49, *that I last saw the deceased alive on* 9-12, 19 49 *and that death occurred at* 1:40 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. F. Ruzicka M. D. | 800 Cathedral | 9-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Sept 15/49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 13 1949 | Mrs. Virginia Williams, M.D. | Frank Enoch Son | 900 Cathedral |

VS 150

F. F. RUZICKA, M.D. 937 900 Cathedral

G78131 G78131

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

No. 1 Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Harry E.Hunt

2. DATE OF DEATH: Sept.13/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 111 S.Curley St

Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
111 S.Curley St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md. 1-2
D. STREET ADDRESS (If rural, give location): 111 S.Curley St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan.26/91 | 58 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ins. Business
10B. KIND OF BUSINESS OR INDUSTRY: Ind.Life Ins.Co.
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Oscar Hunt
14. MOTHER'S MAIDEN NAME: Mamie Hoffman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary artery disease. | Three weeks |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 24 1949, to Sept 13 1949, *that I last saw the deceased alive on* Sept 13 1949, *and that death occurred at* 8 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm D Schmitt M. D.
23B. ADDRESS: 701 N. Kenwood Ave.
23C. DATE SIGNED: Sept 14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept.16/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949 VS 150
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Philip Henry Sons,
ADDRESS: 2024 Orleans St.

94a

BIRTH NO. G78132

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78132

1. NAME OF DECEASED (Type or Print): WALTER BARTLETT (Bodley)

2. DATE OF DEATH: September 9, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-1
D. STREET ADDRESS (If rural, give location): 831 N. Lexington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Single | | 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Emma Richardson ADDRESS: 853 W. Franklin St.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab Wounds of Chest, multiple

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): and Mulberry Street (found) Intersection of Myrtle Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 9, 1949 approx. 10:30 p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-16-49
24C. NAME OF CEMETERY OR CREMATORY: National Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley & W. Biggs
ADDRESS: 517 N. [illegible]

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CERTIFICATE CORRECTED 9-27-49 ✓ 3rr. r

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78133 Registered No.

G78133

| | |
|---|---|
| NAME OF DECEASED (Type or Print) ANNA TALLEY | 2. DATE OF DEATH September 11, 1949 |
| 3. PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-1 |
| Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 527 W. Biddle Street |
| SEX female / 6. COLOR OR RACE colored / 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH July 5, 1905 1907 / 9. AGE (In years last birthday) 42 44 / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | 10B. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Thomas Talley | 14. MOTHER'S MAIDEN NAME Mildred Anderson |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 215-16-6118 |
| | 17. INFORMANT Mrs Mary Logan ADDRESS 2416 Madison Av. |

## 18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic alcoholism — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Central nervous system syphilis — DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| | | |
|---|---|---|
| 23A. SIGNATURE [signature] M.D | 23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED Sept. 12, 1949 |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION OR REMOVAL (Specify) Burial | 24B. DATE 9-14-'49 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvery Cem. | 24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md. |
| DATE RECEIVED BY REGISTRAR SEP 14 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Francis J. Hensley & W. Biddle St | ADDRESS 578 |

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3134 G78134

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420 Registered No.

TH NO.

1. NAME OF DECEASED (Type or Print) LORETTA REGINA RETTALIATA

2. DATE OF DEATH Sept. 13/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2630 E. Baltimore street

Length of stay in Baltimore: Yrs. Lifetime Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-2
d. STREET ADDRESS (If rural, give location) 2630 E. Baltimore street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Aug. 28, 1878 | 71 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home

10a. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Knight

14. MOTHER'S MAIDEN NAME Mary Bradley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Mr. Joseph J. Rettaliata ADDRESS 2630 E. Baltimore street

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | myocardosis | |
| DUE TO (B) | arteriosclerotic heart disease | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | arteriosclerosis | |
| | hypertension | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1939 *to* Sept 13, 1949, *that I last saw the deceased alive on* Sept 13, 1949, *and that death occurred at* 12 p m., *from the causes and on the date stated above.*

23a. SIGNATURE John J Gould M. D.

23b. ADDRESS 142 East ave

23c. DATE SIGNED 9-13-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/17/49

24c. NAME OF CEMETERY OR CREMATORY New Cathedral

24d. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR Sep 15 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS Chas. F. Evans & Son 118 West Mount Royal ave. Chas. F. Evans & Son, Inc. 93D

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8135 — BALTIMORE CITY HEALTH DEPARTMENT — G78135

# CERTIFICATE OF DEATH

Registered No. 00

STATE FILE NO.

1. NAME OF DECEASED (Type or Print) Williams Wright

2. DATE OF DEATH Sept 13, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 1614 Riggs Ave
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-3
D. STREET ADDRESS (If rural, give location) 1617 Riggs ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years. last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | Col. | | 1898 | 51 | | |

9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER
10B. KIND OF BUSINESS OR INDUSTRY Tavern Bar
11. BIRTHPLACE (State or foreign country) Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Jack Wright
14. MOTHER'S MAIDEN NAME Sarah
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or Yes) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Daisy J. Wright ADDRESS 1614 Riggs ave

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Tuberculosis | 1 yr |
| DUE TO | | |
| (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1949, *to* Sept, 1949, *that I last saw the deceased alive on* July 13, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Douglas Sheppard M.D.
23B. ADDRESS 404 N. Fulton ave
23C. DATE SIGNED 9-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/17/49
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Cem.
24D. LOCATION (City, town, or county) (State) Arbutus Balto. Co. Md.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mehrtholter Funeral Home Inc.
927 N. Mount St.

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8136 — 778136

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): William Bowman
2. DATE OF DEATH: Sept. 14, 1949
3. PLACE OF DEATH: Baltimore City, Maryland — Harriet Lane
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 5228 Denmore Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | | 2-14-1942 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Fred Bailey
14. MOTHER'S MAIDEN NAME: Mildred Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL |

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Leukemia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 3/21, 1949 to 9/14, 1949, that I last saw the deceased alive on 9/14, 1949 and that death occurred at 7:35 P.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison Grenan, M.D. | JOHNS HOPKINS HOSPITAL | 9/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or County) (State) |
|---|---|---|---|
| Burial | Sept 17-49 | Mt Auburn | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 15 1949 | Huntington Williams, M.D. | Wm Brooks | 1463 N. Caroline |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Dr. 1 G78137.

TH NO. Registered No.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) George T. Reinhardt | 2. DATE OF DEATH 13 Sept. 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital (DOA) | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-6 |
| Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 1616 N Durham St. |
| 5. SEX Male / 6. COLOR OR RACE White / 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH July 10, 1881 / 9. AGE (In years last birthday) 68 / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck | 10B. KIND OF BUSINESS OR INDUSTRY B.C. Sanitation Dept. / 11. BIRTHPLACE (State or foreign country) Baltimore / 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME John Reinhardt | 14. MOTHER'S MAIDEN NAME Emma Chambers |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. / 17. INFORMANT Mary Reinhardt ADDRESS 1616 N. Durham St. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Thrombosis | |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| | | |
|---|---|---|
| 23A. SIGNATURE Wm. H. Kammer, Jr. M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED 13 Sept. 1949 |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/17/49 | 24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 24D. LOCATION (City, town, or county) (State) Belair Rd. |
| DATE RECEIVED BY LOCAL REGISTRAR SEP 15 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Clarence F. Hoffmann | ADDRESS 1639 Broadway. |

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8138 ? MAXIE

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

33 Registered No. G78138

1. NAME OF DECEASED (Type or Print): Wm. Maxie

2. DATE OF DEATH: 9/11/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident

Length of stay in Baltimore: 20 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1933 Walbrook Ave
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 933 Walbrook St 15-4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Col | | Aug | 50 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: Labor

11. BIRTHPLACE (State or foreign country): USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Maxie

14. MOTHER'S MAIDEN NAME: Emma Johnson Hamby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT: Annie Maxie ADDRESS: 5015 Fremont Ave

## 18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

I — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Hypostatic pneumonia | |
| DUE TO | | |
| (B) | Cerebral thrombosis | |
| DUE TO | | |
| (C) | Essential hypertension | |

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-1-49, 19__, to 9-10, 1949, that I last saw the deceased alive on 9/11, 1949, and that death occurred at 7:35 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Lewis W. Leppo M. D.

23B. ADDRESS: President Hosp.

23C. DATE SIGNED: 9-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Sept 16 49

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State): Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Isaac L Brown Son ADDRESS: 1040 Montgomery St

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

177 G78139

Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Francis J. Scally

2. DATE OF DEATH: Sept. I3, I949

PLACE OF DEATH: Baltimore City, Maryland Balto Md

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I425 Riverside Ave.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 24-2
D. STREET ADDRESS (If rural, give location): I425 Riverside Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. I5, I883 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER

10B. KIND OF BUSINESS OR INDUSTRY: B AND O R.R.

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Scally

14. MOTHER'S MAIDEN NAME: Margaret McDermott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Sarah C. Scally ADDRESS: I425 Riverside Ave.

## 18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B) —

DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9 yrs ago | Carcinoma of prostate | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept, 19[illegible], *to* Sept 13, 19[illegible], *that I last saw the deceased alive on* Sept 12, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. R. Scarano M. D. | 436 E Fort Ave | 9/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. I6,49 | Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 15 [illegible] | Huntington Williams, M.D. | Flynn & Fleming | I426 Light Street |

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78140 G78140

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

STATE FILE NO.

2. DATE OF DEATH: 9.13.49

NAME OF DECEASED (Type or Print): MRS. EMELIE NOUN.

PLACE OF DEATH: Baltimore City, Maryland (If not in hospital or institution, give street address or location): Church Home Hosp

FULL NAME OF HOSPITAL OR INSTITUTION: Church Home Hospital.

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 1-2
D. STREET ADDRESS (If rural, give location): 109 S. Potomac Street.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | White | Widow. | 4/30/1866. | 83 | | |

5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H
10a. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Baltimore.
12. CITIZEN OF WHAT COUNTRY? U.S. America

13. FATHER'S NAME: John Unger.
14. MOTHER'S MAIDEN NAME: Angela ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.

17. INFORMANT: John Noun. ADDRESS: Jefferson apt 42 32nd St

## CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Hypertension Cardio Vascular disease: | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | | |
| | DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | | |

20. AUTOPSY? YES ☑ NO ☐

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur? —

22. *I hereby certify that I attended the deceased from* 9/12/49 *to* 9/13/49 *that I last saw the deceased alive on* 9/13/49 *and that death occurred at* 3 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dorothy Roberts M. D.
23B. ADDRESS: Church Home Hospital
23C. DATE SIGNED: 9/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-16-49
24C. NAME OF CEMETERY OR CREMATORY: Emanuel Cem
24D. LOCATION (City, town, or county) (State): Greenmount Ave. Baltimore
ADDRESS:
25. FUNERAL DIRECTOR: John C. Miller Inc. 2435 E. Oliver St.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.

VS 150

93D

8141

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 078141 Registered No.

STATE NO.

1. NAME OF DECEASED (Type or Print) Margaret Hoffheiser

2. DATE OF DEATH 8-13-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-7
D. STREET ADDRESS (If rural, give location) 2016 Ellsworth St

Length of stay in Baltimore — Yrs. / Mos. / Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | 8-22-1905 | 44 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Balto. Md. | |

13. FATHER'S NAME Leonard Rathlingsfelder

14. MOTHER'S MAIDEN NAME Mary Heintzel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give year or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no or unknown | | Norman Hoffheiser | 2016 Ellsworth St |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive Heart Disease

DUE TO

(C) Phlebothrombosis, Right leg

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-22, 1949 *to* 9-13-, 1949 *that I last saw the deceased alive on* 8-13, 1949 *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kean M. D. | St Josephs Hospital | 9-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 9-19-49 | Oak Hill Cem. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 13 1949 | Huntington Williams, M.D. | John C. Miller Inc. | 243 E. Oliver St |

VS 150

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78142

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78142

STH NO.

NAME OF DECEASED (Type or Print) CHARLES EDWARD BAUL

2. DATE OF DEATH Sept. 9, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1827 Jefferson St. (?)

Length of stay in Baltimore ? Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | col | Sep. | 6/9/21 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Seafarer | St. Louis, Mo. | USA |

13. FATHER'S NAME Wesley Baul

14. MOTHER'S MAIDEN NAME Nellie Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. 490-12-0125

17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Apr. 18, 1949 *to* Sept. 9, 1949, *that I last saw the deceased alive on* Sept. 9, 1949, *and that death occurred at* 2:58P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 9/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 18 49 | | St. Louis, Mo. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 13 1949 | Huntington Williams, M.D. | Chas O. Wilson | 1000 Bramhall |

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46F

8143 BALTIMORE CITY HEALTH DEPARTMENT 401 ✓ 078143

# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) George W. Baublitz

2. DATE OF DEATH Sept 15, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto. City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 15 27-19
D. STREET ADDRESS (If rural, give location) 5723 Reisterstown Rd.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

Length of stay in Baltimore: Yrs. Mos. Days

| 6. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Nov. 18, 1908 | 40 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk
10B. KIND OF BUSINESS OR INDUSTRY Post Office
11. BIRTHPLACE (State or foreign country) Westminster Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George E. Baublitz
14. MOTHER'S MAIDEN NAME Katherine Sherfey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs. Ruth A. Baublitz ADDRESS 5723 Reisterstown Rd. Wife

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary infarctions, multiple | 9 days |
| DUE TO | | |
| (B) | Mural thrombi, heart | |
| DUE TO | | |
| (C) | Rheumatic myocarditis, acute | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 17, 1949, to Sept. 15, 1949, that I last saw the deceased alive on Sept. 25, 1949, and that death occurred at 8:00 A m., from the causes and on the date stated above.

23A. SIGNATURE John L. Green, E M. D.
23B. ADDRESS Union Memorial Hosp.
23C. DATE SIGNED 9-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 17/49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, Town, or County) (State) Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Loring Byers ADDRESS 505 Park Ave

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8144

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78144
Registered No.

1. NAME OF DECEASED (Type or Print): William Harold Shugars
2. DATE OF DEATH: September 13, 1949
3. PLACE OF DEATH: Baltimore City, Maryland 5202 Beaufort Ave
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Length of stay in Baltimore: 24 years (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5202 Beaufort Ave 27-18
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 15, 1886
9. AGE (In years last birthday): 63 yrs (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10B. KIND OF BUSINESS OR INDUSTRY: Printing
11. BIRTHPLACE (State or foreign country): Hamber, Carroll Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Shugars
14. MOTHER'S MAIDEN NAME: Rose Coolbrider
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-03-8810
17. INFORMANT: Mrs William H Shugars ADDRESS: 5202 Beaufort Ave

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Primary Carcinoma of liver. — INTERVAL BETWEEN ONSET AND DEATH: 15 months

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Metastasis to Gastro-Intestinal Tract. — 12 months

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: June - 1948.
19B. MAJOR FINDINGS OF OPERATION: — Nodular Liver.
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948, *to* Sept. 13, 1949, *that I last saw the deceased alive on* Sept. 12, 1949, *and that death occurred at* 11.15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Earl L. Chambers M. D.
23B. ADDRESS: 4108 Liberty Hts. Ave.
23C. DATE SIGNED: 9/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery
24D. LOCATION (City, town, or county) (State): Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: Loring Byers ADDRESS: 5005 Park Heights Ave

46 F

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G78145

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78145

STH NO.

| | | |
|---|---|---|
| NAME OF DECEASED (Type or Print) | George | Edmonds |
| 2. DATE OF DEATH | Sept. 15, 1949 | |

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 3315 Woodland Ave.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 7-5-1914 | 35 | | | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland Creek, Calvert Co, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Edmonds
14. MOTHER'S MAIDEN NAME: Myrtle Garner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: (Mother) Mrs Albert Bowen ADDRESS: 3315 Woodland Ave

## CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute alcoholism

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Sept. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 17/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15 1949
REGISTRAR'S SIGNATURE: Hunterston Williams, M.D.
25. FUNERAL DIRECTOR: Loring-Byers ADDRESS: 500 S Pork Ave

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78146 CRIST G78146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): SIDNEY R. CRIST

2. DATE OF DEATH: 9/13/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 14-2
d. STREET ADDRESS (If rural, give location): 1137 N. Stricker St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

Length of stay in Baltimore: 15 Yrs. Mos. Days

5. SEX: M
6. COLOR or RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 3/7/1889
9. AGE (In years last birthday): 60
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clinton Crist
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Daughter — ADDRESS: Hagerstown, Md.

## CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxemia; Bed sores;
DUE TO
(B) Alcoholism; Pneumonia
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1 1949 to 9/13 1949 that I last saw the deceased alive on 9/13 1949 and that death occurred at 6:50 p m., from the causes and on the date stated above.

23a. SIGNATURE: Nelson Wells M. D.
23b. ADDRESS: Univ. Hosp.
23c. DATE SIGNED: 9/16/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/17/49
24c. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24d. LOCATION (City, town, or county) (State): 5608 Dogwood Rd
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: SEP 15
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John F. Cowan Inc. Holl

VS 150

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8147 ✓ G78147

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 175

Registered No.

NO.

1. NAME OF DECEASED (Type or Print): Mrs. Edith Faithfull

2. DATE OF DEATH: Sept. 12, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
743 W Balto st
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 4-2
D. STREET ADDRESS (If rural, give location)

| 3. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | Nov 19-1894 | 54 | 9 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | Home | Martinsburg W Va. | |

13. FATHER'S NAME: Milton Powell

14. MOTHER'S MAIDEN NAME: Mary Hockilbe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes or unknown)

16. SOCIAL SECURITY NO

17. INFORMANT: Edward Faithfull ADDRESS: 743 W Balto st

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Carcinoma ovary

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4/25/1949 *to* 9/12/1949, *that I last saw the deceased alive on* 9/12/1949, *and that death occurred at* 5:45 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. Ehrhler M. D. | Bon Secours Hosp | 9/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/17/49 | [redacted] St Peters | West Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 15 1949 | Huntington Williams, M.D. | Charles P Towell | 2427 Edmondson Ave |

SEP 150

49a

G78148

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78148

TH NO.

1. NAME OF DECEASED (Type or Print): LAWRENCE (djm) MOYER N-F61-4

2. DATE OF DEATH: September 14, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-1
d. STREET ADDRESS (If rural, give location): 1117 Sterrett Street

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Aug. 31, 1925 | 24 25 (djm) | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT
10b. KIND OF BUSINESS OR INDUSTRY: V. A. RADIO SCHOOL
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lawrence J. Moyer
14. MOTHER'S MAIDEN NAME: Gertrude Wedel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W. W. II
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Mrs. Gertrude Hughes, ADDRESS: 1117 Sterrett St.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bullet Wounds of Heart | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Front of 1119 Sterrett Street
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 14, 1949 4:15 P.M.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23a. SIGNATURE: Emil H. Beyer M.D.
23b. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23c. DATE SIGNED: 9-15-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: SEPT 19 1949
24c. NAME OF CEMETERY OR CREMATORY: Loudon Park
24d. LOCATION (City, town, or county) (State): 3801 Frederick Ave. ADDRESS

DATE RECEIVED BY REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Harry H. WITZKE, 4101 Edmondson Ave, Balto. 29, Md.

VS 151

166

978149 BALTIMORE CITY HEALTH DEPARTMENT 0 1 0 G78149

# CERTIFICATE OF DEATH

Registered No.

TH NO BC-49-05670

NAME OF DECEASED (Type or Print) Fulton Lee Barr

2. DATE OF DEATH 9-14-49.

PLACE OF DEATH: Baltimore City, Maryland Balto

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 301 S Woodyear 19-03

Length of stay in Baltimore 6 months (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 3-7-49 | | 6 | 7 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Mr. Carroll L. Barr.
14. MOTHER'S MAIDEN NAME Helen Mullane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Carroll L Barr ADDRESS 301 S. Woodyear

## CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous Meningitis.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1949 to Sept 14, 1949, *that I last saw the deceased alive on* Sept. 14, 1949, *and that death occurred at* 3:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE C. J. Cantalano M. D.
23B. ADDRESS 2025 N. Eutaw
23C. DATE SIGNED Sept 14-1949.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-16-49
24C. NAME OF CEMETERY OR CREMATORY St. Peters
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR George A Farley ADDRESS Fells Ave & Wolfe St

VS 150

14

8150 BALTIMORE CITY HEALTH DEPARTMENT G78150

TH NO. **CERTIFICATE OF DEATH** Registered No.

| | |
|---|---|
| NAME OF DECEASED (Type or Print): Minnie Adelaide Schmidt | 2. DATE OF DEATH: September 14, 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland; B. COUNTY |
| FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location) 4019 Chatham Road | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10 |
| Length of stay in Baltimore: Life (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location): 4019 Chatham Road |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Dec. 6, 1872 | 76 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William V. Ramey | Elizabeth Vane |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | None | Mr. J. Paul Schmidt, 1211 Lakeside Ave. |

**CAUSE OF DEATH**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardiovascular disease | 5 yrs |
| DUE TO (B) | Arterioscleorsis | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Hypostatic Pneumonia | 1 day |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 5 *1949, to* Sept 14 *, 1949 that I last saw the deceased alive on* Sept 14 *, 1949, and that death occurred at* 5.30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter S. Tibbitt M. D. | 2220 Garrison Blvd. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 17, 1949 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 15 1949 | Huntington Williams, M.D. | Wolles Lamorsay | 4510 Liberty Heights Ave. |

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): AARON T. HICKMAN

2. DATE OF DEATH: Sept. 15, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 506 N. Chapel Gate Lane

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Crisfield Md.
D. STREET ADDRESS (If rural, give location): 12 E. Chesapeake Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | widowed | Oct. 1867 | 82 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Retired Fisherman
10a. KIND OF BUSINESS OR INDUSTRY: Sea Food - (W)
11. BIRTHPLACE (State or foreign country): Crisfield Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: Mrs. Sie Hickman 1325 Edmondson Balto. Md.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Embolism F. Ventricular — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Chronic Myocarditis — DUE TO — ?
(C) Myocardial degeneration — DUE TO — ?
(D) generalized arteriosclerosis — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Partial Obstruction Ileum ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from August 17, 1949, to Sept. 15, 1949, that I last saw the deceased alive on Sept 15, 1949, and that death occurred at 4.35 P m., from the causes and on the date stated above.

23A. SIGNATURE: Melvin N. Borden M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 9/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 9/15/49
24C. NAME OF CEMETERY OR CREMATORY: Sunny Ridge
24D. LOCATION (City, town, or county) (State): Crisfield Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mildred J. Blight
ADDRESS: 6009 Harford Rd.

VS 150

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 978152

STH NO.

NAME OF DECEASED (Type or Print): Hyman Cohen

2. DATE OF DEATH: 9/15/49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 1-3

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

D. STREET ADDRESS (If rural, give location): 2125 E. Lombard St

Length of stay in Baltimore: Life 47 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W | Married | Dec 16, 1902 | 46 47 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor Man
10a. KIND OF BUSINESS OR INDUSTRY: Manufacturing

11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME: Aaron Cohen

14. MOTHER'S MAIDEN NAME: Lena Yaskin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bleeding peptic ulcer

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9/13 19 49 *to* 9/15 19 49 *that I last saw the deceased alive on* 9/15 19 49, *and that death occurred at* 1 15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. Richard Franel M. D. — 23B. ADDRESS: Mercy Hospital — 23C. DATE SIGNED: 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 9-16-49 — 24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel — 24D. LOCATION (City, Town, or County) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949 — REGISTRAR'S SIGNATURE: Huntington Williams M.D. — 25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

VS 150

117a

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78153

...53 ... TH NO.

NAME OF DECEASED (Type or Print): JOHN H. B. YOUNG

2. DATE OF DEATH: September 13, 1949

PLACE OF DEATH: Baltimore City, Maryland Baltimore, Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chase
D. STREET ADDRESS (If rural, give location): Oliver Beach

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| ale | white | Divorced | ------- | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): etired Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. B. Young
14. MOTHER'S MAIDEN NAME: Margaret Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Doris Bryan ADDRESS: 1119 Evans Way

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour): OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death was in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Sept. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/16/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. Meares and Son ADDRESS: 805 N. Calvert

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94a

154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

76 G78154 Registered No.

TH NO. B.C 49-11770

NAME OF DECEASED (Type or Print): James Leo Boozer

2. DATE OF DEATH: 8/22/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

Length of stay in Baltimore: Yrs. — Mos. — Days 6

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-1
D. STREET ADDRESS (If rural, give location): 403 N Mount St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | N | Single | 8/11/49 | | | 6 | 4 | 30 |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| W I Barn | | Baltimore Md | U S A |

13. FATHER'S NAME: James Leo Boozer

14. MOTHER'S MAIDEN NAME: Martha Lee Poindtie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | | Mrs Martha Boozer | 403 N Mount St |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Premature Birth

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/11/49 *to* 8/22/49 *that I last saw the deceased alive on* 8/22/49 *and that death occurred at* 10:03 *m., from the causes and on the date stated above.*

23A. SIGNATURE: R Eugene W. Redding M.D. | 23B. ADDRESS: 720 N. Wolfe St | 23C. DATE SIGNED: 9/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL | 24D. LOCATION (City, town, or county) (State): SEP 13 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Commissioner of Health | ADDRESS

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No.

BC.49-18199

1. NAME OF DECEASED (Type or Print): Baby Smith
2. DATE OF DEATH: 8-26-49

3. PLACE OF DEATH: Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
Length of stay in Baltimore [redacted] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-1
D. STREET ADDRESS (If rural, give location): 1008 W. Lafayette Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Years) (If under 1 year, months, days, or hours) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | | 8-25-49 | | 1 | 8 |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Stanley Knight
14. MOTHER'S MAIDEN NAME: Ella Mae Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Ella Mae Smith
ADDRESS: 1008 Lafayette Ave

## CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B) Syphilis
DUE TO
(C) Prematurity

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/25, 19[illegible] *to* 8/26, 19[illegible] *that I last saw the deceased alive on* 8/26, 1949, *and that death occurred at* 9:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. Louise Young M. D.
23b. ADDRESS: 1100 Druid Hill Ave.
23c. DATE SIGNED: 8/31/49

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24d. LOCATION (City, town, or county) (State): SEP 13 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO. 49-13072

NAME OF DECEASED (Type or Print) Baby Boy Inman

2. DATE OF DEATH 6/30/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Gwynn Oak
D. STREET ADDRESS (If rural, give location) 104 Carver Rd

Length of stay in Baltimore — Yrs. / Mos. / Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Single | 6/28/49 | | | 1 / 16 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N. Born Infant
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) U.S.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Socrates Inman
14. MOTHER'S MAIDEN NAME Dashi Rhine Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Mother
ADDRESS 104 Carver Rd

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Ingested Poison Strychnine | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/28 1949 *to* 6/30 1949, *that I last saw the deceased alive on* 6/30 1949 *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE Herbert Inman M. D.
23B. ADDRESS Provident Hosp
23C. DATE SIGNED 7/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY John Hopkins Medical Service
24D. LOCATION (City, town, or county) (State)
SEP 13 1949
25. FUNERAL DIRECTOR
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR 7 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
Commissioner of Health

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Carlotta L. Waters

2. DATE OF DEATH Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital

Length of stay in Baltimore 54 das. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE North Carolina
B. COUNTY Beaufort
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Washington
D. STREET ADDRESS (If rural, give location) (Box 186) 212 Riverside Dr.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | White | Single | Jan 7, 1912 | 37 | | |

| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | North Carolina (Belhaven) | United States |

13. FATHER'S NAME: McCoy G. Waters

14. MOTHER'S MAIDEN NAME: Ella Harris

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs. Ella Waters Pfau | Washington, N.C. |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinomatous degeneration of Ulcerative Colitis | 15 months |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) Ulcerative Colitis | 21 months |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 27, 1949 | Extensive Destruction. Meta-static Carcinomatosis | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 24, 1949 *to* Sept. 16, 1949, *that I last saw the deceased alive on* 9/16 1949, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Glenn P. Graves | Union Memorial Hospital | 9/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 9/16/49 | | Washington, N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 16 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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158 ✓ X 60 G78158

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) CORA CLASS

2. DATE OF DEATH Sept 14/49.

PLACE OF DEATH: a. Baltimore City, Maryland — Baltimore City, Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE Hosp.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenarm, Md.
D. STREET ADDRESS (If rural, give location) Hillrise Ave.

Length of stay in Baltimore — Yrs. 12 Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| ♀ F | white | married | July 6th, 1897 | 52 | 2 | 8 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY housewife

11. BIRTHPLACE (State or foreign country) Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME John Smith ?

14. MOTHER'S MAIDEN NAME Florence Schiable

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO

17. INFORMANT Mr. J.C. Class ADDRESS Hillrise Ave.

## CAUSE OF DEATH

18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) pulmonary embolism — DUE TO

(B) varicose veins — DUE TO

(C) syphilitic ligation

INTERVAL BETWEEN ONSET AND DEATH: 6 hours

19A. DATE OF OPERATION Sept 9. 19B. MAJOR FINDINGS OF OPERATION varicose veins

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) /

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) /

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) /

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. /

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? /

22. *I hereby certify that I attended the deceased from* Sept 2, 1949 *to* Sep-14, 19 ✗✗ *that I last saw the deceased alive on* Sept 14, 19 49 *and that death occurred at* 3:10 pm. *from the causes and on the date stated above.*

23A. SIGNATURE Edward Burger M. D. — 23B. ADDRESS Franklin square Hosp - — 23C. DATE SIGNED Sept 14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial — 24B. DATE 9/17/49 — 24C. NAME OF CEMETERY OR CREMATORY St. Johns Lutheran — 24D. LOCATION (City, Town, or County) (State) Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR Sep 16 1949 — REGISTRAR'S SIGNATURE [illegible] — 25. FUNERAL DIRECTOR Lassahn Funeral Home — ADDRESS 7401 Belair Rd.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Flora Hill
2. DATE OF DEATH: 9/13/49
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   a. STATE: Md.
   b. COUNTY: 15-2
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
   d. STREET ADDRESS (If rural, give location): 1806 Mulberry St
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp.
   Length of stay in Baltimore: 40. Yrs. Mos. Days
6. SEX: F
   COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: March 6, 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
    10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Henry Richardson
14. MOTHER'S MAIDEN NAME: Carey Griffin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown): No
    (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Patient — ADDRESS

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Nephrosclerosis (benign) | 1 year ? |
| DUE TO | | |
| (B) | Hypertensive Cardiovascular disease | 19 years |
| DUE TO | | |
| (C) | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/[illegible]9, 1949, to 9/13, 1949, that I last saw the deceased alive on 9/13, 1949, and that death occurred at 11:35 a.m., from the causes and on the date stated above.

23a. SIGNATURE: C. Richard Evans, M. D.
23b. ADDRESS: Mercy Hosp
23c. DATE SIGNED: 9/13/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 16, 1949
24c. NAME OF CEMETERY OR CREMATORY: Williamson W. Va.
24d. LOCATION (City, town, or county) (State): West Virginia
25. FUNERAL DIRECTOR — ADDRESS 3224: Peter R. Williams Schroeder Sh

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH/NO.

NAME OF DECEASED (Or Print) **Ruby Wise**

2. DATE OF DEATH **9-13-49**

PLACE OF DEATH: **Baltimore City, Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 25-32
D. STREET ADDRESS (If rural, give location) **2718 Spelman Road (25)**

Length of stay in Baltimore **23yrs** Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Married | Oct. 19, 1920 | 28 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10a. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **N.C.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Lacy Cable**

14. MOTHER'S MAIDEN NAME **Lillian McRae (Dec.)**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS **Records: Baltimore City Hospitals 4940 Eastern Ave.**

## CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I **DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Chronic Glomerula Nephritis with Uremia**

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B)

DUE TO

(C)

II **OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Cardiac Failure Hypertensive cardiovascular disease**

19A. DATE OF OPERATION **9-5-1949**

19B. MAJOR FINDINGS OF OPERATION **Hematoma of the Abdominal Wall** (over)

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **8-9-** , 19 **49** *to* **9-13-** , 19 **49**, *that I last saw the deceased alive on* **9-13-** , 19 **49**, *and that death occurred at* **11.35AM** *from the causes and on the date stated above.*

23A. SIGNATURE **P.S. Rogers** M. D.

23B. ADDRESS **Baltimore City Hospitals**

23C. DATE SIGNED **9-14-49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **Sept 17, 1949**

24C. NAME OF CEMETERY OR CREMATORY **Mt. Auburn**

24D. LOCATION (City, town, or county) (State) **Baltimore Md**

DATE RECEIVED BY LOCAL REGISTRAR **SEP 16 1949**

REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**

25. FUNERAL DIRECTOR **Mrs Katie R. Williams**

ADDRESS **3224 Schroeder St**

VS 150

56E

G78161

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

STH NO.

1. NAME OF DECEASED (Type or Print): Robert Byrd

2. DATE OF DEATH: September 14th, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Avenue

War-Wid-Da Nursing Home

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-2
D. STREET ADDRESS (If rural, give location): 676 W. Fairmount Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | C | Widowed | June 1, 1853 | 96 | 3 | 13 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gloucester, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Henry Armstrong ADDRESS: 1232 W. Lafayette Ave

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Disease - Arterio Sclerosis — 14 Yr.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 16th, 1949, *to* September 13, 1949 *that I last saw the deceased alive on* 9-13-1949, *and that death occurred at* 7:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. A. Carlson M. D.
23B. ADDRESS: 600 N. Arlington Ave
23C. DATE SIGNED: 9-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-16-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county): Balto. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams
ADDRESS: 951 N. Howard St

VS 150

131a

G78162

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78162 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Charles Jones

2. DATE OF DEATH SEP 15 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-42
D. STREET ADDRESS (If rural, give location) 1006 Parkside Ave

Length of stay in Baltimore 88 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 1-27-61 | 88 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md | |

FATHER'S NAME John Jones

14. MOTHER'S MAIDEN NAME Ellen Sterling

| WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## CAUSE OF DEATH

18. I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Thrombosis of iliac vein - right

DUE TO

(C) Puerperitis

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-4 1949 *to* 9-15 1949 *that I last saw the deceased alive on* 9-15 1949 *and that death occurred at* 4:40 a m., *from the causes and on the date stated above.*

23A. SIGNATURE Weston Jones M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/19/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park | 24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 16 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR Ulrich Funeral Home | ADDRESS 2900 Eastern Ave

VS 150

133a

78163 G78163

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78163

H NO.

NAME OF DECEASED (Type or Print): Mary Anderson

2. DATE OF DEATH: Sept. 15, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 630 W. Franklin St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-1
D. STREET ADDRESS (If rural, give location): 630 W. Franklin St.

Length of stay in Baltimore: Yrs. Mos. Days

SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan. 1, 1879
9. AGE (In years last birthday): 70 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Fred Grant
14. MOTHER'S MAIDEN NAME: Sarah ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): (No or unknown)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Louise Williams — ADDRESS: 630 W. Franklin St.

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: Sept. 1 to 15

DUE TO

(B) arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1-, 1949, *to* 9-15, 1949, *that I last saw the deceased alive on* 9-9-, 1949, *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. R. Amthell, M. D.
23B. ADDRESS: 718 Dolphin St.
23C. DATE SIGNED: 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-17-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Frances A Hemsley — ADDRESS: 578 W. Biddle St.

VS 150

83a

8164 CERTIFICATE CORRECTED 9-20-49 ✓ G78164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Robert Beeks

2. DATE OF DEATH: 9/13/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mary General Hospital

Length of stay in Baltimore: 66 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-2
D. STREET ADDRESS (If rural, give location): 515 So. Kenwood St #24

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | 7/25/1883 | 66 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10a. KIND OF BUSINESS OR INDUSTRY: Gas and Elec Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME: John L. Beeks
14. MOTHER'S MAIDEN NAME: Phoebe Dodde

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 212-05-5450
17. INFORMANT ADDRESS

18. 212-05-5450 CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5-6 days

DUE TO

(B) Arteriosclerotic Heart Disease ?

DUE TO and.

(C) Diabetes mellitus ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Acute congestion of lungs and viscera

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/9, 1949 to 9/13, 1949 *that I last saw the deceased alive on* 9/13, 1949 *and that death occurred at* 5:55 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Cadle | Md. Gen'l Hosp. | 9/13 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sep 17 1949 | Parkwood Cem | Balto. County |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: John H. Welsey 401 S. Chester St

VS 150

61 1

165 — BALTIMORE CITY HEALTH DEPARTMENT — G78165

# CERTIFICATE OF DEATH

416 — Registered No.

TH NO.

NAME OF DECEASED (Type or Print): MARY ELLEN CORNELL

2. DATE OF DEATH: 9-15-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland

Length of stay in Baltimore: Yrs. — Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-1
D. STREET ADDRESS (If rural, give location): 3402 Ravenwood ave.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10-24-83
9. AGE (In years last birthday): 65
If Under 1 Year: Months 10 Days 21
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Malone (Walter Lincoln Corn)
14. MOTHER'S MAIDEN NAME: Mary ann Malone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mabel Dillon — ADDRESS: Same

## 18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebrovascular Accident | |
| | DUE TO Embolus ? | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) auricular fibrillation | |
| | DUE TO Rheumatic Heart Disease | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cardiac Failure | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-14, 1949 *to* 9-15, 1949, *that I last saw the deceased alive on* 9-15, 1949, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. P. Benson, Jr. M.D.
23B. ADDRESS: Hosp. for Women of Md.
23C. DATE SIGNED: 9-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MARYLAND

VS 150, [illegible] 95B

166

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 v

Registered No. 778166

TH NO.

NAME OF DECEASED (Type or Print): AGNES MILANICZ

2. DATE OF DEATH: September 14, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1803 Aliceanna Street

Length of stay in Baltimore: Yrs. 70 Mos. Ds.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-3
D. STREET ADDRESS (If rural, give location): 1803 Aliceanna Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | March 23, 1868 | 81 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Glinski
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mrs. Constance Gruszczynski
ADDRESS: 1807 Aliceanna

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arteriosclerotic C-V Renal di'ease. | ? |
| DUE TO (B) | Auricular fibrillation. | 3 yrs. |
| DUE TO (C) | Oedema, ascites. | 6 mos. |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: none

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan., 1948 *to* 14 Sept., 1949 *that I last saw the deceased alive on* 14 Sept. 1949 *and that death occurred at* 6.45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Drozd M. D.
23B. ADDRESS: 2601 Eastern Ave.
23C. DATE SIGNED: 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Ellington Williams, M.D.
25. FUNERAL DIRECTOR: M. F. Sadowski & Sons
ADDRESS: 1808 Eastern Avenue

VS 150

131a

8167

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78167
Registered No.

TH NO.

1. NAME OF DECEASED (Type or Print): FRANCES-JANKOWSKI (COSKI)

2. DATE OF DEATH: Sept. 16-1949

3. PLACE OF DEATH: Baltimore City, Maryland — Balto City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2009 Fleet St

Length of stay in Baltimore: 60 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 2-3
D. STREET ADDRESS (If rural, give location): 2009 Fleet St.

5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Dec. 21-1888
9. AGE (In years last birthday): 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Andrew Jazynski
14. MOTHER'S MAIDEN NAME: Mary Graczkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —

17. INFORMANT: Margret Coski — ADDRESS: 2709 Preston St.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Cardiac Dilatation | 1 day |
| DUE TO (B) | Chronic Myocarditis | 5 yrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS. IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from June 2 1949 to Sept. 16, 1949 that I last saw the deceased alive on Sept. 15 1949 and that death occurred at 6 A. m., from the causes and on the date stated above.

23A. SIGNATURE: John V. Szczepicki M. D.
23B. ADDRESS: 1802 Eastern Ave
23C. DATE SIGNED: 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Sept. 19-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Fialkowski — ADDRESS: 2007 Eastern Ave

VS 150

937

-131742
3168

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G78168 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Gertrude Elizabeth Fiedler

2. DATE OF DEATH: 9-15-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-3
D. STREET ADDRESS (If rural, give location): 911 Fells St. zone 31

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| | White | Widowed | 9-13-1898 | 51 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Holland
14. MOTHER'S MAIDEN NAME: Fannie Thorne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia
DUE TO Pulmonary Edema
(B) Hypertensive Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10, 1949, *to* 9-15-, 1949, *that I last saw the deceased alive on* 9-15-, 1949, *and that death occurred at* 2.45P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-15-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Eastern ave Ext

DATE RECEIVED BY LOCAL REGISTRAR: Sep 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Wm Cook Inc
ADDRESS: 1217 St Paul St

93D

78169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78169

NO.

1. NAME OF DECEASED (Type or Print) ALVERTA - CULLEY

2. DATE OF DEATH 9/14/49

PLACE OF DEATH: Baltimore City, Maryland 2629 MAISEL ST

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NONE

Length of stay in Baltimore 31 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO 25-43
D. STREET ADDRESS (If rural, give location) 2629 MAISEL ST

3. SEX F.

6. COLOR OR RACE WHT

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW

8. DATE OF BIRTH DEC 13-1877

9. AGE (In years last birthday) 71 (If Under 1 Year: Months 9, Days 7; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10B. KIND OF BUSINESS OR INDUSTRY NO

11. BIRTHPLACE (State or foreign country) KENT COUNTY MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOHN GODWIN

14. MOTHER'S MAIDEN NAME RACHEL DOWNS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO NOD

17. INFORMANT MRS. RENA DAVIS ADDRESS 2629 MAISEL ST

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma - Cervix Uteri — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

(B)

DUE TO Cerebral Metastases.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* June 10 49 *to* Sept 14 19 49, *that I last saw the deceased alive on* 9/13 49, *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE John C. Schenuch M. D.

23B. ADDRESS 1337 S. Clarke St

23C. DATE SIGNED 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE 9/17/49

24C. NAME OF CEMETERY OR CREMATORY WESLEY CHAPEL.

24D. LOCATION (City, town, or county) (State) ROCKHALL

DATE RECEIVED BY LOCAL REGISTRAR SEP 16 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Geo H. Leimbach ADDRESS 525 N. Eutaw St

VS 150

48a

78170 — BALTIMORE CITY HEALTH DEPARTMENT — 43 — 078170

# CERTIFICATE OF DEATH

TH NO. 78170 — Registered No. 078170

NAME OF DECEASED (Type or Print): Jose Fernandezy

2. DATE OF DEATH: Sept. 14, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-3
D. STREET ADDRESS (If rural, give location): 1700 Thames St. 2nd floor

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SEAMAN | MARITIME | SPAIN | U.S |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: National Maritime Union — ADDRESS: 1012 E. Balto St

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Herbert J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Sept. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9/17/49

24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart

24D. LOCATION (City, town, or county) (State): Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Lilly & Zeller — ADDRESS: 403 S. Wolfe

VS 151

Fernandezy

937

MEDICAL EXAMINER TO APPROVE CERTIFICATE

978171

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 978171

H NO.

NAME OF DECEASED (Type or Print): Elizabeth A. Fowble

2. DATE OF DEATH: 9/15/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 9-7
D. STREET ADDRESS (If rural, give location): 1529 Abbottston St #18

Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1-1-1875 | 74 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10a. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Reisterstown, Md.
12. CITIZEN OF WHAT COUNTRY?

CERTIFICATION APPROVED BY
R S Fisher
for: C.J. Lubinski, M.D.
CHIEF OR ASSISTANT MEDICAL EXAMINER

13. MOTHER'S MAIDEN NAME: Mary E. Swem

14. FATHER'S NAME: John George Bausman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mr. Charles E. Bausman 1316 Longwood St.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute & chronic cholecystitis & lithiasis with cholangitis & choledocholithiasis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) and Diabetes mellitus — ?

DUE TO

(C) and Arteriosclerotic cardio-vascular disease & decompensation jaundice Fracture, rt shoulder → 2 2 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Patient fell out of bed at home address above
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 - 14 - 49 ~3 p m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [✓]
21F. HOW DID INJURY OCCUR? Pt ill, attempted to get up & fell

22. I hereby certify that I attended the deceased from 9-14, 1949 to 9-15, 1949 that I last saw the deceased alive on 9-15, 1949 and that death occurred at [illegible] p.m., from the causes and on the date stated above.

23A. SIGNATURE: [illegible] Collins M. D.
23B. ADDRESS: md. gen'l Hosp.
23C. DATE SIGNED: 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Pleasant Hill Cem.
24D. LOCATION (City, town, or county) (State): Owings Mills, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Tunstall for Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

CERTIFICATE PENDING APPROVAL OF DR. LUBINSKI Medical Examiner Protocol 186a To follow

8172 G78172

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No.

NO.

NAME OF DECEASED (Type or Print): Augusta Mc Nancy

2 DATE OF DEATH: Sept 15-1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 24-4
D. STREET ADDRESS (If rural, give location): 109 E. Fort Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 109 E. Fort Ave.

Length of stay in Baltimore: 65 Yrs. Mos. Days

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov. 1-1878 | 70 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): House wife
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Berger
14. MOTHER'S MAIDEN NAME: Augusta Lehman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: William Mc Nancy ADDRESS: 109 E. Fort Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral Hemorrhage | 18 hrs. |
| DUE TO (B) | Hypertensive Cardio Vas Disease | 2 yrs. |
| DUE TO (C) | Hypostatic Pneumonia | 2 days |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/14/49, 19__, to 9/15/49, 19__, that I last saw the deceased alive on 9/14/49, 1949, and that death occurred at 3.30 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Walter Kohn M. D.
23B. ADDRESS: 102 E Fort Ave
23C. DATE SIGNED: 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/17/1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): G. G. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Flynn + Fleming ADDRESS: 1426 Light St.

VS 150

63B

# CERTIFICATE CORRECTED 2-3-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

8173 — G78173 Registered No.

NAME OF DECEASED (Type or Print): JOHN H. McKEITHEN

2. DATE OF DEATH: Sept. 15, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-1
D. STREET ADDRESS (If rural, give location): 113 Barre St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | 9/26/~~10~~ 1909 | 39 ~~38~~ | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Beth. Steel | Johnsboro, N.C. | U.S.A. |

13. FATHER'S NAME: John McKeithen

14. MOTHER'S MAIDEN NAME: Minnie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Estelle McKeithen — ADDRESS

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obliterative coronary sclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocardial hypertrophy (hypertensive heart disease)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher - M.D. | | Sept. 16, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-18-49 | Mt. Calvary | B.A. Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Charles L. Law - 802 Mad. Ave.

VS 151

937

78174 G78174

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78174

1. NO.

NAME OF DECEASED (Type or Print): Maude Harvey

2. DATE OF DEATH: 9/15/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION: University Hospital

Length of stay in Baltimore: Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md. B COUNTY: Carroll
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Westminster Route #5
D STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | Oct. 8, 1873 | 75 76 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B KIND OF BUSINESS OR INDUSTRY: At home
11 BIRTHPLACE (State or foreign country): Gibson City, Illinois
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: J. Ralph Lott
14 MOTHER'S MAIDEN NAME: Olive R. King

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO: None
17. INFORMANT: pt Kenoff ADDRESS: Deceased

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepato-renal syndrome? — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Ca of gallbladder with liver metastases — 1 wks or months
DUE TO
(C) Cholelithiasis — several years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Cholecystectomy performed 9/14/49 — 1 year
Interventricular, generalized arteriosclerosis CVD

19A. DATE OF OPERATION: 7/4/49
19B MAJOR FINDINGS OF OPERATION: Cholelithiasis; Ca of gallbladder with metastases
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/12, 1949, to 9/15, 1949, *that I last saw the deceased alive on* 9/15, 1949, *and that death occurred at* 11:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John R. Hankins M. D.
23B ADDRESS: University Hospital
23C. DATE SIGNED: 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Sept. 18, 1949
24C. NAME OF CEMETERY OR CREMATORY: Monkton Methodist Cem.
24D LOCATION (City, town, or county) (State): Monkton, Balto Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John Burns' Sons, Towson, Md.
ADDRESS

VS 150

46F

G78175

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78175 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Samuel Hoover

2. DATE OF DEATH September 13, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-2
D. STREET ADDRESS (If rural, give location) 1632 Pennsylvania Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore 22 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | 6-5-06 | 43 | | | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer
10B. KIND OF BUSINESS OR INDUSTRY BLDG. CONST
11. BIRTHPLACE (State or foreign country) N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Hoover
14. MOTHER'S MAIDEN NAME Francis Marsh
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-20-4696
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriolar nephrosclerosis & uremia | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Hypertensive Cardio vascular disease | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchopneumonia, organism (?) | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7 1949 *to* 9-13 1949 *that I last saw the deceased alive on* 9-13 1949, *and that death occurred at* 12 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE Adolph H. Schauwecker, M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 9/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE Sept 17 1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Co.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 16 1949
REGISTRAR'S SIGNATURE Hunterstown, Pennsylvania, Md.
25. FUNERAL DIRECTOR Mrs. Lottie Gross 140 Eastland Ave.

VS 150

131a

78176 G78176

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

260 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Joseph John Hladky Sr

2. DATE OF DEATH 9-16-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-1
D. STREET ADDRESS (If rural, give location) 805 N. Linwood Ave.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Dec. 10, 1881 | 67 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None BRAKEMAN
10B. KIND OF BUSINESS OR INDUSTRY Penna R.R.
11. BIRTHPLACE (State or foreign country) Slavakia (Czechoslavakia)
12. CITIZEN OF WHAT COUNTRY? U.S.

FATHER'S NAME Michael Hladky
14. MOTHER'S MAIDEN NAME Mary Chereaseo

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Joseph John Hladky ADDRESS

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Amputation of rt. leg — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Diabetic Gangreene

DUE TO

(C) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 9/14/49
19B. MAJOR FINDINGS OF OPERATION Gangreene of rt. leg
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* 6/26 1949, *to* 9/16 1949 *that I last saw the deceased alive on* 9/16 1949, *and that death occurred at* 5 40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE R. F. Thewlis M.D. M. D.
23B. ADDRESS Maryland General Hospital
23C. DATE SIGNED 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 19, 1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Belair Rd., Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Schimunek Funeral Home Inc
ADDRESS 2601-03-05 E. Madison Street

VS 150

61

781'77

TH NO. 49-18631

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G781'77

AME OF DECEASED (e or Print): Baby Girl Mahon(died)

2. DATE OF DEATH: September 4, 1949

LACE OF DEATH: Baltimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1026 Ashland Court

10-2

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| ale | White | S. | September 4, 1949 | | | 1 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: mes Mahon

14. MOTHER'S MAIDEN NAME: Mary Frances Spitaletta

WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 N. Broadway

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Anencephaly | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September 4 19 49 *to* Sept. 4, 19 49 *that I last saw the deceased alive on* Sept. 4, 19 49 *and that death occurred at* 5:56A m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. A. Anderson M. D.

23B. ADDRESS: 601 North Broadway

23C. DATE SIGNED: 9-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Hoop Pleasant

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: SEP 17 1949

REGISTRAR'S SIGNATURE: Timothy Williams, MD

25. FUNERAL DIRECTOR

ADDRESS

VS 150

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781178 ✓ X G781178

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

774 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Baby Girl Wyatt

2. DATE OF DEATH: Sept. 6/1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Churchville
d. STREET ADDRESS (If rural, give location)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | | 9-5-49 | | | | 4 | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

FATHER'S NAME: Antie Wyatt

14. MOTHER'S MAIDEN NAME: Hazel ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Septicemia | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Septicemia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George Blumenthal M. D. | JOHNS HOPKINS HOSPITAL | 9-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 17 1949 | Huntington Williams, M.D. | | |

VS 150 Hospital Disposal 159

131793
G78179

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78179

TH NO. B.C. 49-20540

| | |
|---|---|
| NAME OF DECEASED (Type or Print) | Baby Boy Davis |
| 2. DATE OF DEATH | 9-9-1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Baltimore City Hospitals 4940 Eastern Ave. |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 11-4 |
| D. STREET ADDRESS (If rural, give location) | 1208 Madison Ave. |
| Length of stay in Baltimore — Yrs. / Mos. / Days | Life |
| SEX | |
| 6. COLOR OR RACE | Negro |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | Single |
| 8. DATE OF BIRTH | 9-9-1949 |
| 9. AGE (In years last birthday) — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min. | 8 |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10a. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| FATHER'S NAME | James Davis |
| 14. MOTHER'S MAIDEN NAME | Ruby ? |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT'S NAME AND ADDRESS | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 9-9- , 1949 *to* 9-9- , 1949 *that I last saw the deceased alive on* 9-9- 1949 *and that death occurred at* 1.30PM *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | M. D. | 23B. ADDRESS: Baltimore City Hospitals |
| 23C. DATE SIGNED | 9-15-1949 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Cremated | |
| 24B. DATE | 9-10-1949 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Baltimore City Hospitals | |
| 24D. LOCATION (City, town, or county) (State) — ADDRESS | 4940 Eastern Ave. Baltimore, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 14 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, MD | |
| 25. FUNERAL DIRECTOR | | |

VS 150

159

78180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78180

NO.

| | |
|---|---|
| NAME OF DECEASED (or Print) | Edward Anderson |
| 2. DATE OF DEATH | July 25, 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D STREET ADDRESS (If rural, give location) | 4002 Pennington Ave. |
| LL NAME OF ITAL OR ITUTION (If not in hospital or institution, give street address or location) | 4002 Pennington Ave. |
| ngth of stay in Baltimore (Yrs. Mos. Days) | |
| X | Male |
| 6. COLOR OR RACE | White |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | Married |
| 8. DATE OF BIRTH | 9/20/1895 |
| 9 AGE (In years last birthday) | 53 |
| If Under 1 Year Months Days | |
| If Under 24 Hours Hours Min. | |
| USUAL OCCUPATION (Give kind of during most of working life, even if retired) | Machinist |
| 10B. KIND OF BUSINESS OR INDUSTRY | ? Unemployed |
| 11. BIRTHPLACE (State or foreign country) | Balto..Md. |
| 12 CITIZEN OF WHAT COUNTRY? | |
| ATHER'S NAME | Henry Anderson |
| 14 MOTHER'S MAIDEN NAME | Sophia Kline |
| AS DECEASED EVER IN U. S ARMED FORCES? or unknown) (If yes, give war or dates of service) | |
| 16 SOCIAL SECURITY NO | |
| 17 INFORMANT ADDRESS | Mrs. Mary Anderson - Above |

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute Coronary Occlusion | ? |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Hypertensive Cardio Vascular Dis. | |
| | DUE TO (C) Exogenous Obesity | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* May 1, 1949 *to* July 25, 1949 *that I last saw the deceased alive on* July 22, 1949, *and that death occurred at* 4 A. m. *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Paul Luban M.D W. D. | 23C. DATE SIGNED 9/3/49 |
| 23B. ADDRESS | 320 Watrous Ave | |
| A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 7/27/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Balto..National | |
| 24D. LOCATION (City, town, or county) (State) | Balto. Md. | |
| TE RECEIVED BY CAL REGISTRAR | SEP 17 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, MD | |
| 25. FUNERAL DIRECTOR ADDRESS | Wm. Cook, Inc., Balto. Md. | |

VS 150

92D

78181

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

160.0

78181 Registered No.

TH NO. B.C.49-20351

NAME OF DECEASED (Type or Print) Baby Girl Coldwell

2. DATE OF DEATH 9-16-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore Newborn Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk.
D. STREET ADDRESS (If rural, give location) 1817 Bell Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 9-12-49 | | | 4 |

10. USUAL OCCUPATION (Give kind of one during most of working life, even if retired)
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Mercy Hospital
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Roland C. Coldwell
14. MOTHER'S MAIDEN NAME Mary Ann Rosselcin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Roland C. Coldwell ADDRESS 1817 Bell Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Spinal tap | Xanthochromic fluid | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-12 19 49 *to* 9-16, 19 49, *that I last saw the deceased alive on* 9-16, 19 49 *and that death occurred at* 12:30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. M. Boswell, Jr. M. D. | Mercy Hosp | 9-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | 9-17-49 | Mt. Olivet | Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 17 1949 | Huntington Williams, M.D. | J. Stan E. Dunphy, Inc. | 715 Light St. 30 |

VS 150

160a

3182 — 678182

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): FREDERICK H. HENNIGHAUSEN

2. DATE OF DEATH: Sept. 14, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5411 Falls Road Terrace

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-15
D. STREET ADDRESS (If rural, give location): 5411 Falls Road Terrace

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan. 5, 1894 | 55 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lawyer | Own Law Firm | Baltimore, Md. | |

13. FATHER'S NAME: Percy C. Henninghausen

14. MOTHER'S MAIDEN NAME: Lizette Hobelmann

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes — World War #1 | none | Mr. Charles E. Henninghausen | 5411 Falls Rd. Terr |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Cardio-Vascular

DUE TO

(B) disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?15+ yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* January 1946 *to* Sept 1949, *that I last saw the deceased alive on* Sept 14, 1949, *and that death occurred at* 3:00 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G Helfrich M. D. | 5006 Roland Ave | Sept 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/17/49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93c

78183 BALTIMORE CITY HEALTH DEPARTMENT G78183

# CERTIFICATE OF DEATH

Registered No.

H NO.

NAME OF DECEASED (Type or Print): JOSEPH CLARENCE ALBRIGHT

2. DATE OF DEATH: 9-15-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

Length of stay in Baltimore: Yrs. 2 Mos. 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RIDERWOOD
D. STREET ADDRESS (If rural, give location): OLD COURT ROAD

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | NOV 15, 1895 | 53 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MECHANICAL ENGINEER | ENGINEERING | ILLINOIS | USA |

13. FATHER'S NAME: JOHN M. ALBRIGHT

14. MOTHER'S MAIDEN NAME: JANE ALLEN

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | World War I | | Mrs. H. W. Albright | Riderwood, Md. |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute pulmonary edema

DUE TO

(B) acute myocardial infarction

DUE TO

(C) Coronary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug. 26, 1949, to Sept 15, 1949, *that I last saw the deceased alive on* 15 Sept, 1949, *and that death occurred at* 10:40 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H. Watt Jr. M. D. | Union memorial Hospital | 9/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 9-17-49 | Loudon Park | Frd. Av. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 17 1949 | Huntington Williams, M.D. | John O. Mitchell Sons | 1900 Eutaw Place |

VS 150

94a

184

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078184

TH NO.

1. NAME OF DECEASED (Type or Print): Catherine O'Brien

2. DATE OF DEATH: Sept 15 1949

PLACE OF DEATH: Baltimore City, Maryland

3a. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) — A. STATE: 124 S. East ave

B. COUNTY:

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-10

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): 124 S. East ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Oct 4, 1868 | 80 87 | 11 | 4 |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home Wife | — | Maryland | U. S. |

13. FATHER'S NAME: Louis Lamm

14. MOTHER'S MAIDEN NAME: Catherine Lantz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: none

17. INFORMANT: Elizabeth Burkhardt — ADDRESS: 124 S. Eastern

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DIABETES MELITIS

DUE TO

(B) COMA.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 10 YEARS OR MORE

19a. DATE OF OPERATION: NONE

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify): X

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: X m.

21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 1939 *to* Sept 15 1949, *that I last saw the deceased alive on* Sept. 15 1949 *and that death occurred at* 8 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Allen R. Bareham M. D.

23b. ADDRESS: 3139 E. Baltimore St

23c. DATE SIGNED: Sept. 15-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept 19, 49

24c. NAME OF CEMETERY OR CREMATORY: Oaklawn

24d. LOCATION (City, town, or county) (State): Eastern ave

DATE RECEIVED BY LOCAL REGISTRAR: SEP 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: S. Walter May — ADDRESS: 619 N. Bouldin St.

VS 150

61

8185 BALTIMORE CITY HEALTH DEPARTMENT 078185

# CERTIFICATE OF DEATH

Registered No.

H NO B. C. 49-19842

NAME OF DECEASED (Type or Print) Barbara Ann Brown

2. DATE OF DEATH Sept 16, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 107 Murdock Road

Length of stay in Baltimore: Yrs. / Mos. / Days 1

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | Sept 15, 1949 | | | 21 / 40 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Darrell Franklin Brown

14. MOTHER'S MAIDEN NAME Vivian Ruth Warner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT Hospital Records ADDRESS

## CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhagic disease of newborn

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B) Erythro blastosis fetalis

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 15, 1949, to Sept 16, 1949, *that I last saw the deceased alive on* Sept 16, 1949, *and that death occurred at* 3:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Albert H. Dudley M. D.

23B. ADDRESS Union Memorial Hospital

23C. DATE SIGNED Sept 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept. 17-1949

24C. NAME OF CEMETERY OR CREMATORY Woodlawn

24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 17 1949

REGISTRAR'S SIGNATURE [illegible] Williams, M.D.

25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078186

TH NO.

NAME OF DECEASED (Type or Print) Anne C. Kenny

2. DATE OF DEATH 9/15/49

PLACE OF DEATH: Baltimore City, Maryland City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md 8-1
D. STREET ADDRESS (If rural, give location) 3107 Marco Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | married | Mar 30-1879 | 70 | | | | |

5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Diggs
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Thomas Kenny ADDRESS 3107 Marco Ave

## CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

| 23a. SIGNATURE | M.D. | 23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23c. DATE SIGNED |
|---|---|---|---|
| John R Davis | | | 9/16/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 19-49 | New Cathedral | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 17 1949 | Huntington Williams, MD | Jos J. Herr & Son 3001 Kentucky Ave |

S151

937

8187 | BALTIMORE CITY HEALTH DEPARTMENT | 078187

# CERTIFICATE OF DEATH

Registered No.

H NO.

NAME OF DECEASED (or Print): Richard McNair

2 DATE OF DEATH: Sept. 14, 1949.

PLACE OF DEATH: Baltimore City, Maryland — 340 N. Bruce St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 340 N. Bruce St

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY: 340 N. Bruce St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-1
D. STREET ADDRESS (If rural, give location): 340 N. Bruce St.

| SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| male | C | Single | Aug. 27, [illegible] | 68 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Tire d Porter. R.R. Pensioner
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME: Richard Mc nair.
14 MOTHER'S MAIDEN NAME: Isabelle

WAS DECEASED EVER IN U. S ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Mollie Walker. ADDRESS: 340 N. Bruce

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arthritis —

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 12, 1949, to Sept 14, 1949, *that I last saw the deceased alive on* Sept 12, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Douglas Sheppard M. D.
23B. ADDRESS: 404 N. Fulton Ave
23C. DATE SIGNED: 9/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-17-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md
DATE RECEIVED BY LOCAL REGISTRAR: SEP 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Katie R. Williams & Sons
ADDRESS: 392

VS 150

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78188

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17°

Registered No. 078188

TH NO.

NAME OF DECEASED (Type or Print): Agnes Ludwig

2. DATE OF DEATH: Sept 15-1949

PLACE OF DEATH: Baltimore City, Maryland 712 E Fort Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-2
D. STREET ADDRESS (If rural, give location): 712 E Fort Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov 28, 1899 | 50 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? Grispen
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (no or unknown):
16. SOCIAL SECURITY NO:
17. INFORMANT: John Ludwig ADDRESS: 712 E. Fort Ave

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Breast.
DUE TO
(B)
DUE TO
(C) Metastases to Thoracic Vertebral.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?: —

22. *I hereby certify that I attended the deceased from* August 13 19 49 to Sept 15 19 49 *that I last saw the deceased alive on* Sept 14, 1949, *and that death occurred at* 7 05 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A. Scheurich M. D.
23B. ADDRESS: 1337 S. Charles St
23C. DATE SIGNED: 9/16/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Sept 17-49
24C. NAME OF CEMETERY OR CREMATORY: Mount Olivet
24D. LOCATION (City, town, or county) (State): Frederick Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph Rasinskas Inc. ADDRESS: 612 Wood

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G78189

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78189

H NO.

NAME OF DECEASED (Type or Print): Charles E. Cole

2 DATE OF DEATH: 9/16/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27 N. Carey St.

Good Samaritan Home

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 8-5
D. STREET ADDRESS (If rural, give location): 2003 Cliftwood Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 11/18/1862 | 86 | 4 / 28 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas Collector
10B. KIND OF BUSINESS OR INDUSTRY: Gas Regulator Co.

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel H. Cole

14. MOTHER'S MAIDEN NAME: Rebecca (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Vernon C. Cole ADDRESS: 2003 Cliftwood Ave.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Congestive Failure | 6 hr 25 Min |
| ANTECEDENT CAUSES | DUE TO (B) Arteriosclerotic Cardio-Vasc Disease | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) Hemorrhage Rectally - Origin undetermined | 2 hr. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/10 *1949, to* 9/16 *, 1949, that I last saw the deceased alive on* 9/16 *, 1949, and that death occurred at* 4:25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul R. Zeigler M. D.
23B. ADDRESS: 3723 Edmondson Ave
23C. DATE SIGNED: 9/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Greek Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Gotsch & Sons ADDRESS: 27 N. Carey St.

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BALTIMORE CITY HEALTH DEPARTMENT 43 G78190

# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (or Print): Ida L. Dempsey

2. DATE OF DEATH: Sept 16 1949

PLACE OF DEATH: Baltimore City, Maryland 5440 Belair Road

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gardenville Convalesent Home

Length of stay in Baltimore: 93 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-34
D. STREET ADDRESS (If rural, give location): 5440 Belair Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Sept 20 1855 | 93 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | At home | Baltimore Md | |

13. FATHER'S NAME: Thomas Shackelford

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. W. R. Dempsey 135 S. Symington Ave |

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Arteriosclerosis

DUE TO

Hypertensive Cardio-Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 10, 1949 *to* Sept 16, 1949 *that I last saw the deceased alive on* Sept 14, 1949 *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. T. Harlocker M. D. | 4706 Harford Road | 9-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 19 1949 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 17 1949 | Huntington Williams M.D. | Harry Hancock | 4204 Ridgewood Ave |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

H43 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Chester Bradley

2. DATE OF DEATH September 14/1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-2
D. STREET ADDRESS (If rural, give location) 530 N. Arlington Ave.

Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 6-25-1896 | 53 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Hotel | S. Carolina | U.S.A. |

FATHER'S NAME Aaron Bradley

14. MOTHER'S MAIDEN NAME Emma Cook

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio vascular disease
DUE TO: Cardiac enlargement, aortic insufficiency & chronic cardiac decompensation, mild
(B) Arterio sclerotic cardio vasc. disease
DUE TO:
(C) Generalized arterio sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES X NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-14, 1949 *to* 9-14, 1949 *that I last saw the deceased alive on* 9-14, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edgar H. Schaumach M. D. | JOHNS HOPKINS HOSPITAL | 9/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-19-49 | Mt. Calvary Cem | Anne Arundel Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 17 1949 | Carrington Williams, M.D. | Mrs Frances A. Kemsley - W. Biddle St. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

NAME OF DECEASED (or Print): Victoria Ennis

2. DATE OF DEATH: Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland — Baltimore

ALL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Former Home for Aged Little Sisters of the Poor

Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 10-1
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | 6. | W | 1865 | 81 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: PRIVATE FAMILY
11. BIRTHPLACE (State or foreign country): Annapolis Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ennis Budden
14. MOTHER'S MAIDEN NAME: Maiden unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lilian Dymkins ADDRESS: 1200 Valley St

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Edema Lungs | 2 days |
| DUE TO (B) | Chronic Myocarditis | 8 yrs |
| DUE TO (C) | Burger's Disease | 3 yrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: April 7 - 1949
19B. MAJOR FINDINGS OF OPERATION: Obliterating endarteritis - Gangrene -
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1 , 1949, to Sept 16 , 1949, *that I last saw the deceased alive on* Sept 15 , 1949 *and that death occurred at* 6:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: E Gill Hall M. D.
23B. ADDRESS: 1631 E North Ave
23C. DATE SIGNED: Sept 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 19/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): Frederick Road Md
DATE RECEIVED BY LOCAL REGISTRAR: SEP 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Robert J Elliott
ADDRESS: 1129 N. Carrollton

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78193 G78193

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

N NO.

NAME OF DECEASED (Or Print) Joseph Konopka

2. DATE OF DEATH Sept 16 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1020 S. Linwood Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1020 S. Linwood Ave

Length of stay in Baltimore Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov 1874 | 74 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | ? | Poland | |

FATHER'S NAME Stanislaus Konopka

14. MOTHER'S MAIDEN NAME ?

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Alexandria Konopka | 1020 S Linwood Ave |

## CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Jan 2, 1949 *to* Sept 16, 1949 *that I last saw the deceased alive on* Sept 15, 1949 *and that death occurred at* 2:20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE Andrew Kourouvacki M. D.

23B. ADDRESS 2579 Eastern Ave.

23C. DATE SIGNED 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept 19 1949

24C. NAME OF CEMETERY OR CREMATORY St Stanislaus

24D. LOCATION (City, town, or county) Dundalk Ave Md (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP 17 1949

REGISTRAR'S SIGNATURE Charlington Williams, MD

25. FUNERAL DIRECTOR John J Duda ADDRESS 2829 Hudson St

93D

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54 Registered No. G78194

TH NO.

NAME OF DECEASED (or Print) Miss Margaret Duddy

2. DATE OF DEATH Sept. 17, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa. B. COUNTY ?

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Willis - Barre 2-1

Length of stay in Baltimore 7 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 189 S. Washington St.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 12/25/1883 | 65 66 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Nurse | Public Health | Ireland | U. S. A. |

FATHER'S NAME Patricia Duddy

14. MOTHER'S MAIDEN NAME Susan Dougherty

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | Unknown | Deceased | |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinomatosis | 2 yrs ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Carcinoma of Rectum | 2 yrs ? |
| | DUE TO (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Myocardial Disease | 2 yrs ? |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 3/26/49 | Carcinoma of Rectum | YES ☐ NO ☒ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 25, 1949 *to* Sept. 17, 1949 *that I last saw the deceased alive on* Sept. 16, 1949 *and that death occurred at* 11:50 a.m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| [signature] | Mercy Hospital | 9/17/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 9/17/49 | St. Mary's Cem. | Hanover Town Twp. Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 17 1949 | [signature] Washington Williams, M.D. | Wm. J. Tickner & Sons, Inc. | 467 North Penna. Aves. Baltimore (17) Md. |

VS 150

G78195

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78195 Registered No.

TH NO.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) Ralph Dixon | 2. DATE OF DEATH SEP 16 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE S. Carolina B. COUNTY |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greer |
| Length of stay in Baltimore Yrs. 0 Mos. Days | D. STREET ADDRESS (If rural, give location) 70 W. Poinsett St |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 4-28-23 | 26 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Factory Worker | MFG. SHIRTS | Georgia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Hubbard Dixon | Mittie Hicks |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL | |

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lethalgy ? Fallot — INTERVAL BETWEEN ONSET AND DEATH: Life

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral thrombosis ? — 4 hrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/16/49 | Lethalgy ? Fallot | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9-13- 1949 *to* 9-16- 1949, *that I last saw the deceased alive on* 9-16 1949, *and that death occurred at* 6:00 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | JOHNS HOPKINS HOSPITAL | 9/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 9/20/49 | Greer Cemetery | S Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 18 1949 | [signature] | Charles S Towell & Co | 2427 Edmondson Ave |

VS 150

157-E

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78196 (STATE NO.) — G78196 Registered No.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) | Ernestine E. Battle |
| 2. DATE OF DEATH | Sept. 15, 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | Balto. City |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 519 N. Bethel Ct. |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | 7-5 |
| C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) | Baltimore |
| Length of stay in Baltimore (Yrs. Mos. Days) | 7 yrs. |
| D. STREET ADDRESS (If rural, give location) | 519 N. Bethel ~~St.~~ Ct. |

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | | Jan. 16-1938 | 11 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School Child | | Battleboro N. C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Batt: Battle | Ellen Sucao |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Ellen Battle 519 N. Bethel St |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Septicemia | |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* **Autopsy** (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Sept. 16, 1949 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 18-49 | Woodard cem. | Whitakers N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S ADDRESS |
|---|---|---|
| SEP 18 1949 | Huntington Williams, M.D. | Chas O. Wilson 1000 Bronty |

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**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

0 0 1

Registered No.

H NO.

NAME OF DECEASED (Type or Print): Doris Epps

2. DATE OF DEATH: Sept. 15-49

PLACE OF DEATH: Baltimore City, Maryland Balto. City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 331 W. Preston St

Length of stay in Baltimore: 8 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-4
D. STREET ADDRESS (If rural, give location): 331 W. Preston St

| SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Single | Feb. 8. 1932 | 17 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | | Nelson Co. Va | U. S. A. |

15. FATHER'S NAME: William Fulton Epps

14. MOTHER'S MAIDEN NAME: Evelyn Jackson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William F. Epps | 331 W. Preston |

## 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Probable 6-8 mo.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Mar 20 1949 *to* Sept 15, 1949, *that I last saw the deceased alive on* Sept 15, 1949, *and that death occurred at* 9 P.M. *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| H. Harland Russell M. D. | 902 W. Franklin | 9-17-49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 19-49 | Oak Hill cem. | Amherst Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Brantley ave |

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Ada Close

2. DATE OF DEATH: Sept. 17, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. 6 Mos. Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md. B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Westminster Rural
D. STREET ADDRESS (If rural, give location):

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | 1880 | 69 | | |

| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | — | Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Andrew Drechsler | Caroline Long |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | None | Mabel Shaffer | Westminster, Md. |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial decompensation
Arteriosclerotic heart disease
& hypertension - auric. fibrillation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intracerebral hemorrhage
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Sept. 15, 1949, to Sept. 17, 1949, that I last saw the deceased alive on 9/17, 1949, and that death occurred at 6:05 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fred R. McDaniel Jr. M.D. | University Hospital | 9/17 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Fairview Mem. | Westminster RD 4 Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | H. Bayard Dor | Westminster, Md. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

ME OF DECEASED or Print) Harry J Miller

2. DATE OF DEATH Sept. 16, 1949.

ACE OF DEATH: ltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

LL NAME OF ITAL OR ITUTION (If not in hospital or institution, give street address or location) 1701 Ellamont St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 512

ength of stay in Baltimore 60 yrs Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3615 Reisterstown Road

| X | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| le | White | Married | 1882 | 67 | | | | |

| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| helham Steel Co | Helper Tool Room | Russia | USA |

ATHER'S NAME arles Killer

14. MOTHER'S MAIDEN NAME Jennie Berman

| WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Celia Miller | 3615 Reisterstown Rd |

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Bladder | 1 yr. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Diabetes Mellitus | 2 yr. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| | | | |

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949 *to* Sept. 16, 1949 *that I last saw the deceased alive on* Sept. 16, 1949 *and that death occurred at* 9:05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] Linstadt | Emerson Hotel | 9/17/49 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 18, 1949 | Hebrew Rosedale Cem | Baltimore Md |

| ATE RECEIVED BY CAL REGISTRAR 18 1949 | REGIS[illegible] | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Sol Levinson & Bros | 1126 W North Ave |

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G78200

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78200 Registered No.

H NO.

ME OF DECEASED (or Print) Jennie Posner

2. DATE OF DEATH Sept, 16, 1949

ACE OF DEATH: ltimore City, Maryland

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location) 1226 E Baltimore St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-1
D. STREET ADDRESS (If rural, give location) 1226 E Baltimore St

ength of stay in Baltimore 45 yrs (Yrs. Mos. Days)

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | Married | Sept 14, 1890 | 59 | | | | |

10. USUAL OCCUPATION (Give kind of one during most of working life, even if retired) use Wife
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lith
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Aaron Sugar
14. MOTHER'S MAIDEN NAME Fannie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Samuel Posner ADDRESS 1226 E Baltimore St

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis
DUE TO
(B) Hypertensive Cardio-Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 10K, 1949 to Sept. 16K, 1949 *that I last saw the deceased alive on* Sept 16, 1949, *and that death occurred at* 8.15p m., *from the causes and on the date stated above.*

23A. SIGNATURE Morris A. Fine M. D.
23B. ADDRESS 116 Fairmount Ave
23C. DATE SIGNED Sept 17K '49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 18, 1949
24C. NAME OF CEMETERY OR CREMATORY Hebrew Rosedale Cem
24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949
REGISTRAR'S SIGNATURE Thurlington for Williams M.D.
25. FUNERAL DIRECTOR Sol Levinson & Bros ADDRESS W North Ave 1126

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

H NO.

1. NAME OF DECEASED (Type or Print): ABE MARCUS

2. DATE OF DEATH: 9-17-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): Arlington Park Apts

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | | 52 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mfg
10A. KIND OF BUSINESS OR INDUSTRY: Ladies Suits
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?: ✓

13. FATHER'S NAME: Louis Marcus
14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or Unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Celia Marcus - Arlington Park ADDRESS:

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, Cardiac Failure
DUE TO & Pulmonary Embolism
(B) ASHD
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-16, 1949, *to* 9-17, 1949, *that I last saw the deceased alive on* 9-17, 1949, *and that death occurred at* 10:15 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Conrad H. Michael M. D.
23B. ADDRESS: Sinai Hosp. Balto.
23C. DATE SIGNED: 9-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-19-49
24C. NAME OF CEMETERY OR CREMATORY: Arlington
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

93D

G78202

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78202

TH NO.

NAME OF DECEASED (Type or Print): REBECCA SCHWARTZ

2. DATE OF DEATH: Sept. 17, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-4
D. STREET ADDRESS (If rural, give location): 1808 East Fayette St

Length of stay in Baltimore: 38 Yrs. Mos. Days

SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 68 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Lazar Fisher
14. MOTHER'S MAIDEN NAME: Razel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Alvin Leptz ADDRESS: 2624 Fa[illegible]

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | |
| DUE TO (B) | Coronary Thrombosis | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Hypertension & Arteriosclerotic Heart Disease | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Acute Chronic Cholecystitis | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 14, 1949, to Sept 17, 1949, *that I last saw the deceased alive on* Sept 17, 1949, *and that death occurred at* 4:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leon E Kassel M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 9/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-18-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

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G78203

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 Registered No. G78203

8

NAME OF DECEASED (Type or Print) MARY J. FOX

2. DATE OF DEATH Sept 16. 1949

PLACE OF DEATH: Baltimore City, Maryland Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1121 Carroll St

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-2
D. STREET ADDRESS (If rural, give location) 1120 Washington Blvd

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W. | Widowed | Jan 6. 1871 | 78 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Meekins
14. MOTHER'S MAIDEN NAME Augusta Bloom
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT John C. Lyons ADDRESS 1121 Carroll St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Hypertensive C-V-Dis. c Failure
DUE TO
(C) Atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 6, 1949, to Sept. 16, 1949, that I last saw the deceased alive on Sept 15 1949, and that death occurred at 3:15 A m., from the causes and on the date stated above.

23A. SIGNATURE Chas. S. Clark M. D.
23B. ADDRESS 6007 York Road
23C. DATE SIGNED 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 19/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore
24D. LOCATION (City, town, or county) (State) City

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mr. & Mrs. John W. Tengel & Son ADDRESS 5311 Edmondson ave

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): REV. REMY FAC O.F.M CONV.

2. DATE OF DEATH: 9-17-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DON SECOURS HOSPITAL

Length of stay in Baltimore: 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND. B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ELLICOTT CITY
D. STREET ADDRESS (If rural, give location): MISSION HOUSE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | SINGLE | 8-19-93 | 56 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RELIGIOUS – PRIEST
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: FR. ALFRED, ADDRESS: MISSION HOUSE - ELLICOTT CITY, MD

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) UREMIA | 4 DAYS |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Ac. Pyelonephritis | 4 Days. |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cirrhosis of Liver | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12, 1949 *to* 9-17, 1949, *that I last saw the deceased alive on* 9-17, 1949, *and that death occurred at* 1:30A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leo G. Hartman M. D.
23B. ADDRESS: 1037 N. Calvert St.
23C. DATE SIGNED: 9-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: SEPT 21-1949
24C. NAME OF CEMETERY OR CREMATORY: ST. STANISLAUS
24D. LOCATION (City, town, or county) (State): SHAMOKIN PENNA

DATE RECEIVED BY REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George A Weber ADDRESS: 705 S. Conn st

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Charles R. Lawrence

2. DATE OF DEATH: 9-17-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hosp.

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bangor
D. STREET ADDRESS (If rural, give location): Seneca Park Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 24 Jul 1910 | 39 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Builder
11. BIRTHPLACE (State or foreign country): Balto. Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles A. Lawrence
14. MOTHER'S MAIDEN NAME: Ida E. Carbach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-09-2770
17. INFORMANT: Mrs. Charles R. Lawrence — ADDRESS

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: Emil L. Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 9/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/20/49
24C. NAME OF CEMETERY OR CREMATORY: Edgewood
24D. LOCATION (City, town, or county) (State): Balto. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Rd

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BALTIMORE CITY HEALTH DEPARTMENT 31

# CERTIFICATE OF DEATH

Registered No. 3

H NO.

NAME OF DECEASED (or Print): Teresa Wagner

2. DATE OF DEATH: Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland — Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the aged Little Sisters of the Poor

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1200 Valley St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | S. | Nov 26, 1875 | 73 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Wagner

14. MOTHER'S MAIDEN NAME: Teresa Wolf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lena Dynakins — ADDRESS: 1200 Valley St

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Edema of Lungs | 2 days |
| DUE TO (B) | Cerebral Hemorrhage | 7 days |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Arteriosclerosis | 5 yrs |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1949, to Sept 16, 1949, *that I last saw the deceased alive on* Sept 16, 1949, *and that death occurred at* 8:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Gill Hall M. D.

23B. ADDRESS: 1631 E. North Ave

23C. DATE SIGNED: Sept 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Sept 19/49

24C. NAME OF CEMETERY OR CREMATORY: Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Rita Wiedefeld — ADDRESS: 83a

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 60

TH NO.

NAME OF DECEASED (Type or Print): Thomas Edward Halloran

2. DATE OF DEATH: 17 Sept. 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1109 Brentwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-1
D. STREET ADDRESS (If rural, give location): 1109 Brentwood Ave

Length of stay in Baltimore: Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Feb 8 1885 | 64 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ass't Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Steam work
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Halloran
14. MOTHER'S MAIDEN NAME: Julia Sullaha
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Cardio-Vascular Disease with Pulmonary Edema. | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) Diabetes Mellitus | 10 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 17 Sept. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 20/49
24C. NAME OF CEMETERY OR CREMATORY: St. Peters
24D. LOCATION (City, Town, or county) (State): Baltimore
ADDRESS

DATE RECEIVED BY REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Hamilton Williams, M.D.
25. FUNERAL DIRECTOR: Rita Wiedefeld

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G78208 — 750 G7820808

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO. B.C. 49-19412

NAME OF DECEASED (Type or Print): Baby Wyant.

2. DATE OF DEATH: 9-16-49

PLACE OF DEATH: Baltimore City, Maryland 2025 W. Fayette St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 10, 27-14
D. STREET ADDRESS (If rural, give location): 4536 Schenley Road

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Single | 9-16-49 | | | 0 45 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10a. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: Leonard Russell Wyant

14. MOTHER'S MAIDEN NAME: Virginia Pearl Evans

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Anencephaly
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 16, 1949 *to* Sept. 16, 1949 *that I last saw the deceased alive on* Sept. 16, 1949, *and that death occurred at* 8:05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul O. Iannuzzi M. D.
23B ADDRESS: Bon Secours Hospital
23C. DATE SIGNED: 9/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: 9-19-49
24C. NAME OF CEMETERY OR CREMATORY: New Catholic Trial (Co
24D LOCATION (City, town, or county) (State): Baltimore, Md. Finder in the Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Thomas J. Kenny Inc.
ADDRESS: 1600 Hollins St.

157c

803 G78209

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

6.8.09

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Mrs. Laura Alma Farrell

2 DATE OF DEATH: Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
d. STREET ADDRESS (If rural, give location): 3717 West Garrison Avenue.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3717 West Garrison Ave.

Length of stay in Baltimore: Yrs. Mon. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | July 6, 1882 | 67 | 2 | 10. | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Duties
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boston Mass.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Mr. Simeon Gates
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Frank Farrell ADDRESS: 3717 W. Garriso

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Liver — INTERVAL BETWEEN ONSET AND DEATH: 7/12/49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 12, 1949 to Sep. 16, 1949, *that I last saw the deceased alive on* Sep 16, 1949 *and that death occurred at* 3:12 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John D Bukat M. D.
23B. ADDRESS: 4803 York Knights Rd
23C. DATE SIGNED: Sep 17. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 19 1949
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
24D. LOCATION (City, town, or county): Baltimore (State): Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jessie L. Syfer ADDRESS: 1600 W. North ave 46F

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78210 MONROE 078210

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

179 Registered No. 511249

H NO.

NAME OF DECEASED (Type or Print) Oscar Monroe 511249

2. DATE OF DEATH SEP 18 1949

PLACE OF DEATH: Baltimore City, Maryland Brady - 2

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Charles
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pomfret
D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore — Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 4-29-78 | 71 | | |

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10B. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Md. — 12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME Robert Monroe

14. MOTHER'S MAIDEN NAME Elizabeth Ennis

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Gas Gangrene - Left leg. Amputation of left leg. | 4 days |
| DUE TO | Femoral artery Thrombosis | |
| ANTECEDENT CAUSES | Radical dissection of Lymph Nodes | 17 days. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | Cancer of the Penis | 1 month |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATIONS 8/19/49; 8/27/49; 9/10/49; 9/13/49

19B. MAJOR FINDINGS OF OPERATION Cancer of Penis; Radical Lymph Node dissection; Gas Gangrene.

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/18/49 *to* 9/18/49 *that I last saw the deceased alive on* 9/18, 1949, *and that death occurred at* 2:12 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE J. S. Gallert M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 9/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept. 20-49

24C. NAME OF CEMETERY OR CREMATORY Pomfret Cem.

24D. LOCATION (City, town, or county) (State) Pomfret Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949

REGISTRAR'S SIGNATURE Emily Taylor Williams

25. FUNERAL DIRECTOR Hewett & Ryon ADDRESS Waldorf Md.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

2 DATE OF DEATH Sept. 16, 1949

ME OF DECEASED (or Print) HELEN GORDON CARR

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 404 N. Hilton St.

ACE OF DEATH: ltimore City, Maryland

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location) 404 N. Hilton St.

ngth of stay in Baltimore — Yrs. Mos. Days

| X | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| ale | White | Widow | May 24, 1892 | 57 | | |

USUAL OCCUPATION (Give kind of ne during most of working life, even if retired) urse, Unemployed

10B KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) Baltimore, Md.

12 CITIZEN OF WHAT COUNTRY?

ATHER S NAME William Eichelberger

14 MOTHER S MAIDEN NAME Marie Burdette

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown)

16. SOCIAL SECURITY NO

17 INFORMANT M. Virginia Kleintank, 404 N. Hilton St. ADDRESS

## CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

8. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Inoperable Carcinoma - spleen - Liver - Lungs — about 9 mo.

DUE TO

(B) Carcinoma of Spleen — 7

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Aug 1, 1949, to Sept 16, 1949, *that I last saw the deceased alive on* Sept. 15, 1949, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Walter Schubert M. D.

23B ADDRESS 2220 Harlem Blvd

23C. DATE SIGNED Sept 17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/20/49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949

REGISTRAR S SIGNATURE Huntington Williams, MD

25 FUNERAL DIRECTOR William Cook, Inc., 1217 St. Paul St. ADDRESS

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78212 G78212

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 17°

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Lillie Schmus

2. DATE OF DEATH: 9/18/49

PLACE OF DEATH: Baltimore City, Maryland — 27 N. Carey ST

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaratain Hospital

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
d. STREET ADDRESS (If rural, give location): 1113 Scott Street

SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May - 1883
9. AGE (In years last birthday): 66 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife Forelady
10b. KIND OF BUSINESS OR INDUSTRY: Sherer & Dohme Bldg. Co.

11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Bernhardt Schmus
14. MOTHER'S MAIDEN NAME: Margaret Renter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Rose Smith — ADDRESS: 1914 Rutland Ave

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Left Breast c metastasis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized cachexia

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/18, 1949, *to* 9/18, 1949, *that I last saw the deceased alive on* 9/17, 1949, *and that death occurred at* 12:54 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul R. Ziegler, M. D.
23B. ADDRESS: 3723 Edmondson Ave
23C. DATE SIGNED: 9/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/21/49
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St Paul St

VS 150

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8213

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 778213

H NO.

NAME OF DECEASED (or Print): CARVILLE B. COUNCILMAN

2 DATE OF DEATH: Sept. 16, 1949

ACE OF DEATH: ltimore City, Maryland

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location): 4700 Hampnett Ave.

ength of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 5622 Midwood Ave.

| EX | 6. COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| e | White | Married | Mar. 20, 1885 | 64 | | |

| USUAL OCCUPATION (Give kind of ... during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cab Driver | Diamond Cab Co | Baltimore, Md. | |

ATHER'S NAME: Carville Councilman

14 MOTHER'S MAIDEN NAME: Emma Bamberger

| WAS DECEASED EVER IN U.S. ARMED FORCES? (... or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| D | | | Edith Councilman | 5622 Midwood, Ave. |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arterio Cerebral Edema | 10 mos |
| ANTECEDENT CAUSES | DUE TO (B) Hypertension Arteriosclerosis | 2 yrs + |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10 days *1949, to* 17 Sept *, 1949, that I last saw the deceased alive on* 17 Sept *, 1949, and that death occurred at* 11:-0 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| F. Rowe Hooper M. D. | 3534 Harlin Ave | Sept 17-49 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/20/49 | Loreland Park | Baltimore County, Md. |

| TE RECEIVED BY CAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, MD | William Cook, Inc., | 1217 St. Paul St. |

VS 150

82a

78214 MEDICUS 77° 078214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

TH NO. 49-28520 Registered No.

NAME OF DECEASED (Type or Print) Raymond Medicus

2. DATE OF DEATH 9-17-49

PLACE OF DEATH Baltimore City, Maryland 922 Ridgley St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto B. COUNTY City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 922 Ridgley St. 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Dec 8, 1948 | | 9 / 9 | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto.

12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME Thomas Medicus Jr.

14. MOTHER'S MAIDEN NAME Eleanor Grimm

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Eleanor Medicus ADDRESS 922 Ridgley St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Marasmus. — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-17- 1949, *to* 9-17 1949 *that I last saw the deceased alive on* 9-17, 1949, *and that death occurred at* 9:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J. Gleso M. D. | 2730 N. Charles St | 9/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT 19-49 | GLEN HAVEN CEM | GLEN BURNIE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams M.D. | Bernard C. Hoke | 121 E. Hoed St |

VS 150

158

78215 Krueger ✓ E 903.7 G78215

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Fredericka L. Krueger — N-8 M.D. — 2. DATE OF DEATH 9-15-49

PLACE OF DEATH: Baltimore City, Maryland — 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harford Nursing Home — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-5

Length of stay in Baltimore 4 Yrs. 4 Mos. Days — D. STREET ADDRESS (If rural, give location) 2040 Cliftwood Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 7-5-1853 | 96 yrs | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10B. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) Germany — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Samuel Oathen — 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Pauline E. Eader — ADDRESS 2040 Cliftwood Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Fracture neck Lft Femur | 1 month |
| DUE TO (B) | General Arteriosclerosis and Arterial Hypertension | 2 years |
| (C) | | |

CERTIFICATION APPROVED BY

19A. DATE OF OPERATION August 18, 1949 — 19B. MAJOR FINDINGS OF OPERATION Fracture surgical neck of Femur — CHIEF DEPUTY, MEDICAL EXAMINER — M.D. — 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Fell on Kitchen floor — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2040 Cliftwood Ave. Baltimore, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) August 15, 1949 - 1 P. m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ — 21F. HOW DID INJURY OCCUR? Got tobacco and fell on Kitchen floor

21F. HOW DID INJURY OCCUR? After sitting on Couch stood up and lost balance and fell on kitchen floor

22. I hereby certify that I attended the deceased from Aug 15, 1949 to September 15 1949, that I last saw the deceased alive on September 14 1949, and that death occurred at 9 15 P m., from the causes and on the date stated above.

23A. SIGNATURE Albert Oesenberg M. D. — 23B. ADDRESS 2025 E. North Ave — 23C. DATE SIGNED September 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried — 24B. DATE 9-19-49 — 24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem. — 24D. LOCATION (City, town, or county) (State) North Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949 — REGISTRAR'S SIGNATURE Huntington Williams M.D. — 25. FUNERAL DIRECTOR John P. Mullinix — ADDRESS 2435 E. Oliver St.

VS 150

186a

MILK ✓

78216

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

63

78216 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Paul Milk

2. DATE OF DEATH Sept. 16 1949

PLACE OF DEATH: Baltimore City, Maryland Dalen 6

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-10
D. STREET ADDRESS (If rural, give location) 37 S. East Ave

Length of stay in Baltimore — Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 1-19-86 | 63 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Core Molder | Mfg. Iron Castings | Md | |

13. FATHER'S NAME John Milk

14. MOTHER'S MAIDEN NAME Mary Roelt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS JOHNS HOPKINS HOSPITAL

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary abscesses | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Pulmonary cancer | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/7 *, 19*47*, to* 9/16 *, 19*49*, that I last saw the deceased alive on* 9/16 *, 19*49*, and that death occurred at* 2 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wester Orono M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 20/49 | Parkwood | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Williams, M.D. | Wilmot Funeral Hom | 2008 Orleans |

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8217

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78217

TH NO.

1. NAME OF DECEASED (Type or Print) SAMUEL H SAKS

2. DATE OF DEATH 9-19-49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2015 No Pulaski St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-04
D. STREET ADDRESS (If rural, give location) 2015 No Pulaski St

Length of stay in Baltimore: Yrs. 40 Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Furniture

11. BIRTHPLACE (State or foreign country) Lith

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME David

14. MOTHER'S MAIDEN NAME Ada

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Ida Saks ADDRESS 2015 N. Pulaski St

## CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach with metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 years P

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardio-Vascular Disease P

20. AUTOPSY? YES ☐ NO ☑

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION —

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 49 to 9-19, 19 49 *that I last saw the deceased alive on* 9-18, 1949 *and that death occurred at* 2:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE R. A. Aronson M. D.

23B. ADDRESS 1109 N. Calvert St

23C. DATE SIGNED 9-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-19-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D

VS 150

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778218

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 778218

TH NO.

NAME OF DECEASED (or Print) FLEHINGER, WILLIAM

2. DATE OF DEATH 9/18/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-11
D. STREET ADDRESS (If rural, give location) 3402 CALLOWAY AV.

Length of stay in Baltimore 60 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | | 73 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Salesman
10B. KIND OF BUSINESS OR INDUSTRY MFG - MENS WORK CLOTHING
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Rob Knowen
14. MOTHER'S MAIDEN NAME Mol Knowen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Peter Spectre ADDRESS 704 Pimlico Rd

## CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

(B) Acute coronary occlusion

DUE TO

(C) ASHD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/17, 1949 *to* 9/18, 1949, *that I last saw the deceased alive on* 9/18, 1949, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23A. SIGNATURE William Knabaner M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 9/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-19-49
24C. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew
24D. LOCATION (City, town, or county) (State) Balto Md
25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 19
REGISTRAR'S SIGNATURE Huntington Williams, M.D.

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9-19

8219

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078219

TH NO.

NAME OF DECEASED (or Print) BRUNO GATTO

2 DATE OF DEATH 9-17-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-03
D. STREET ADDRESS (If rural, give location) 310 Whitridge Ave.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 5-12-96 | 53 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10B. KIND OF BUSINESS OR INDUSTRY Coat Shop
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME Joseph Gatto
14. MOTHER'S MAIDEN NAME Theresa Frustaci

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 215-10-0924
17. INFORMANT Josephine Gatto ADDRESS wife same

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO → (B) Coronary atherosclerosis indef.

DUE TO → (C) Arteriosclerotic heart disease, diffuse

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-15-1949 *to* 9-17-1949, *that I last saw the deceased alive on* 9-17-1949, *and that death occurred at* 2:00 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE A. F. Judd M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 9-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/21/49
24C. NAME OF CEMETERY OR CREMATORY Cathedral Cem.
24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY REGISTRAR SEP 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS
ADDRESS Balto., Md.

VS 150

937

78220 BALTIMORE CITY HEALTH DEPARTMENT G78220

# CERTIFICATE OF DEATH

Registered No.

H NO. B.C. 49-19781

NAME OF DECEASED (Type or Print): Baby Boy Alvis

2. DATE OF DEATH: 9-16-49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4301 Powell Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

Length of stay in Baltimore: Years / Months / 1 Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 9-15-49 | | | 1 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Alvis
14. MOTHER'S MAIDEN NAME: Mary Wunderlich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert Alvis ADDRESS: 4301 Powell Ave

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: Spinal tap
19B. MAJOR FINDINGS OF OPERATION: W.N.L.
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-15, 1949 to 9-16, 1949 *that I last saw the deceased alive on* 9-16, 1949 *and that death occurred at* 6 1/2 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Emmanuel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck - 5305 Harford Rd.
ADDRESS

VS 150

160a

8221 — G78221

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

774 Registered No.

TH NO. B.C. 49-9473 GHRY

NAME OF DECEASED (Type or Print): Baby ELLER

2 DATE OF DEATH: Sept 16, 1949

PLACE OF DEATH: Baltimore City, Maryland — St. Joseph's Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital

Length of stay in Baltimore: 2 Yrs. ½ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Baltimore, Md
B COUNTY: Baltimore
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md Parkville
D STREET ADDRESS (If rural, give location): 1411 Taylor Ave. Balto Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | infant | Sept 14, 1949 | | 0 | 2 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| infant | infant | Baltimore, Maryland | US |

13. FATHER'S NAME: Arnold Avery Eller
14. MOTHER'S MAIDEN NAME: Joan Lucille Hagerman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | | |

## CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B) Prematurity

DUE TO

(C)

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| | | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 15, 1949, *to* Sept 16, 1949, *that I last saw the deceased alive on* Sept 15, 1949, *and that death occurred at* 12:55 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Pete L. Cooper M. D. | St Joseph's Hospital | Sept 16, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-19-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | J. J. Fleck | 5305 Harford Rd. |

VS 150

159

C. Abrams
20 Eutaw Place.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 978222

TH NO.

NAME OF DECEASED (Type or Print): Henry Hamilton Potter

2. DATE OF DEATH: Sept. 16-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3301 Dorchester Rd.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3301 Dorchester Road 15-11

Length of stay in Baltimore: Yrs. Mos. Days

SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Apr. 8-1885
9. AGE (In years last birthday): 64 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst.-shipping dept.
10B. KIND OF BUSINESS OR INDUSTRY: Edelsyn Co.
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: John J. Potter
14. MOTHER'S MAIDEN NAME: Amanda J. Durkee

WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Albert Kuddle ADDRESS: 3301 Dorchester

## CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Dilatation
DUE TO: Chronic Myocarditis
INTERVAL BETWEEN ONSET AND DEATH: 1/4 hr. / 8 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO: Obesity (Pituitary)
INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

20. AUTOPSY? YES ☐ NO ☑

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1925, *to* Sept 16, 1949, *that I last saw the deceased alive on* Sept 16, 1949, *and that death occurred at* 31 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Medora A Abrams M. D.
23B. ADDRESS: 1820 Eutaw place
23C. DATE SIGNED: Sept 18, 49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 19-1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Hollins, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford Rd.

937

VS 150

8223

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 678223

H NO.

2. DATE OF DEATH: 9/17/49

NAME OF DECEASED (or Print): HARRY M. LORD

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glencoe
D. STREET ADDRESS (If rural, give location):

Length of stay in Baltimore: Yrs. 60, Mos. life, Days

SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 12/21/86
9. AGE (In years last birthday): 62 53
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): real estate
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Co.
12. CITIZEN OF WHAT COUNTRY? Md.

FATHER'S NAME: Charles Lord
14. MOTHER'S MAIDEN NAME: Alice Sowerwine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: CHARLES G. LORD
ADDRESS: 205 Longwood Rd, Balto.

## CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

(B) Arteriosclerosis, Generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Pneumonia, Permanent Arrest

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION (from history)
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/14 19 49 *to* 9/17, 1949, *that I last saw the deceased alive on* 9/17, 1949, *and that death occurred at* [illegible] *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Black M. D.
23B. ADDRESS: Mary Land General
23C. DATE SIGNED: 9/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Greenmount Ave
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25 FUNERAL DIRECTOR: John O. Mitchell Hons 1908 Eutaw Place

95c

VS 150 27681

G78224

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

1. NAME OF DECEASED (Type or Print): Miss Mary T. Lynne

2. DATE OF DEATH: 9-18-49.

PLACE OF DEATH: Baltimore City, Maryland — Balto

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 19-2
D. STREET ADDRESS (If rural, give location): 9 N. Fulton Ave. Balto. 23.

Length of stay in Baltimore: 5-0 yrs (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | S. | 12-31-76 | 72 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work
10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Ireland.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Lynne

14. MOTHER'S MAIDEN NAME: Elizabeth Kieran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) ✓ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Mamie Lynne — ADDRESS

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction.

DUE TO

(B) Hypertensive, Arteriosc-

DUE TO

(C) lerotic Cardiovascular disea-

se.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12, 1949 *to* 9-18, 1949 *that I last saw the deceased alive on* 9-18, 1949 *and that death occurred at* 6.30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. J. Castellaw M. D. | 23B. ADDRESS: 2025 W. Fayette. | 23C. DATE SIGNED: 9-18-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9/21/49 | 24C. NAME OF CEMETERY OR CREMATORY: New Cathedral | 24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd. ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD | 25. FUNERAL DIRECTOR: John J. Cowan & Son Wolfe St. 937

VS 150

8225 ✓ 260 G78225

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): John S. Moll, Sr.

2. DATE OF DEATH: 9/17/49

PLACE OF DEATH: Baltimore City Maryland 3129 Normount Ave

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3129 Normount Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 16-07

Length of stay in Baltimore: 64 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Agnes Moll | 2/16-1864 | 85 | 7 | 6 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Treasurer
10a. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Moll
14. MOTHER'S MAIDEN NAME: Anna Schultheis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-12-5344
17. INFORMANT: Mrs Agnes Moll ADDRESS 3129 Normount Ave

## CAUSE OF DEATH

18.

I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C-V Disease

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Diabetes Mellitus

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

INTERVAL BETWEEN ONSET AND DEATH: 20 & 40 Last Known

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1949, to Sept 17, 1949, *that I last saw the deceased alive on* Sept 17, 1949 *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward A. Kallins M. D.
23B. ADDRESS: 184 W. North Ave
23C. DATE SIGNED: 9/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 9/20/49
24C. NAME OF CEMETERY OR CREMATORY: Forrest Park
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: 9 19 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, MD
25. FUNERAL DIRECTOR: Charles C. Towell ADDRESS 3427 Edmondson Ave

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Reg. 126893
8226

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

Registered No. 078226

H NO.

NAME OF DECEASED (or Print): SUSIE JOHNSON

2. DATE OF DEATH: Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Av.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-03
D. STREET ADDRESS (If rural, give location): 100 N. Caderia St.

Length of stay in Baltimore: Yrs. Life Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | June 30, 1910 | 39 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10a. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Herman Johnson
14. MOTHER'S MAIDEN NAME: Lucy Hubbard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: B.C.H. Records 4940 Eastern Av. ADDRESS

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Recurrent Cerebral Vascular Accident | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertension | |
| DUE TO | | |
| | (C) Hypertensive Cardio Vascular Disease | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour):
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-14-49, 19__, *to* 9-16, 1949, *that I last saw the deceased alive on* 9-16 1949 *and that death occurred at* 8.45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers, M.D.
23B. ADDRESS: 4940 Eastern Av.
23C. DATE SIGNED: 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas Hopkins
ADDRESS: 513 Carrollton Ave

VS 150

93 D Carrollton Ave

G78227

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G78227

G78227

1. NAME OF DECEASED (Type or Print): Emma L. Pfalzgraf

2. DATE OF DEATH: September 16, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore 9-2
D. STREET ADDRESS (If rural, give location): 4214 Harford Terrace

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | widowed | May 14, 1881 | 68 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis C. Uhl
14. MOTHER'S MAIDEN NAME: Elizabeth Heiner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Union Memorial Hospital records
ADDRESS:

## 18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Hypertensive cardiovascular disease and arteriosclerosis

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 16, 1949, *to* Sept. 16, 1949 *that I last saw the deceased alive on* Sept. 16, 1949, *and that death occurred at* 1 30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Q. Ranson M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: Sept 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 20 1949
24C. NAME OF CEMETERY OR CREMATORY: Bowden Park Cem.
24D. LOCATION (City, town, or county) (State): Balto - Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Cunningham Williams, M.D.
25. FUNERAL DIRECTOR: J. F. Blubert & Son
ADDRESS: 130 Eutaw St

VS 150

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8228 ✓ 771 G78228

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Nellie Bond

2. DATE OF DEATH Sept. 17 /49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2707 Ednicott-Drive

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City

D. STREET ADDRESS (If rural, give location) 2637 Dulaney St. 20-5

Length of stay in Baltimore Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | June 23/1866 | 83 | | | | |

| USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | At Home | England | U.S.A. |

FATHER'S NAME: Frank Tonzek

14. MOTHER'S MAIDEN NAME: Anna Pexley

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | No | Walter Bankard | 601 Packwood Rd |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Cervix - Metastasis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Unknown | Unknown | YES ☐ NO ☑ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from July 15, 1949 to Sept 16, 1949, that I last saw the deceased alive on July 16, 1949, and that death occurred at 2:00 P m., from the causes and on the date stated above.

| 23a. SIGNATURE, M. D. | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Thos. J. Wilson MD | 5804 Edmondson Ave. #28 | 9/19/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Sept-19/49 | Loudon Park Cem. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | F. P. Shippert & Son | 1300 Eutaw Pl. 17 |

VS 150

48a

8229

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 G78229 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): William Henry Wilson

2. DATE OF DEATH: 9/16/1949

PLACE OF DEATH: Baltimore City, Maryland — Balto. City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2331 Druid Hill Ave

Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2331 Druid Hill Ave 12-3

SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10/23/1882
9. AGE (In years last birthday) 66 — If under 1 year: Months, Days; If under 24 hours: Hours, Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Apparatus Cleaner
10B. KIND OF BUSINESS OR INDUSTRY: C & P Tel. Co.
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME: William Henry Wilson
14. MOTHER'S MAIDEN NAME: Unkown

WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO. 212.05.0528
17. INFORMANT — ADDRESS: Marion Wilson 2331 Druid Hill Ave

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 days

DUE TO

ANTECEDENT CAUSES

(B) Hypertension — 7

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Chronic Nephritis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 29, 1949, to 9-16, 1949, *that I last saw the deceased alive on* 9-16, 1949, *and that death occurred at* 10:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chas. P. Immerman M. D.
23B. ADDRESS: 2309 Druid Hill Ave.
23C. DATE SIGNED: 9-19-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/19/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park Cem.
24D. LOCATION (City, town, or county) (State): Arbutus Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Elroy O. Wilson 1000 Brantly Ave.

VS 150

131a

78230 - 130199

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

93 Registered No. G78230

H NO.

AME OF DECEASED (or Print): Marion Pettus

2. DATE OF DEATH: 9-15-49

LACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:

LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01

ength of stay in Baltimore: 9 yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 323 N. Poppleton St.

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| | Negro | Single | Sept. 7, 1931 | 18 | | |

| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Va. | |

FATHER'S NAME: Eddie Meyers

14. MOTHER'S MAIDEN NAME: Mary Pettus

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B. C. H. Records, | 4940 Eastern Ave. |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Astrocytoma of Cerebellum — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) over

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-11-49 | Cesarean Section | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7-9-49, 19__, *to* Sept. 15, 19 49 *that I last saw the deceased alive on* Sept. 15 1949, *and that death occurred at* 2.30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 4940 astern Ave. | Sept. 16 49 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 20-49 | Mt Olivet Cem. | Brooklyn Md |

| ATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | Chas. D. Wilson | 1000 Brantly Md |

VS 150

54a

N. 102536
78231
H NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078231

| | |
|---|---|
| NAME OF DECEASED (Type or Print) | Emma Hooper |
| 2. DATE OF DEATH | Sept. 14 - 49 |
| PLACE OF DEATH: Baltimore City, Maryland | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Baltimore City Hospitals 4940 Eastern Ave. |
| Length of stay in Baltimore | Life (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 23-01 |
| D. STREET ADDRESS (If rural, give location) | 1021 S. Sharp St. |
| 5. SEX | female |
| 6. COLOR OR RACE | Negro |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | Single |
| 8. DATE OF BIRTH | ? |
| 9. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hours: Hours / Min. | 75 yrs |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | ? |
| 14. MOTHER'S MAIDEN NAME | ? |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT ADDRESS | B.C.H. Records, 4940 Eastern Ave. |

## 18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Ventricular Fibrillation | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized Arterioscleriosis HASCVD With L. Hemiparesis | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Senile Dementia | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY YES ☐ NO ☐ X |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 7/2/46 19__, *to* 9/14 19 49, *that I last saw the deceased alive on* 9/14 19 49, *and that death occurred at* 10AM *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| C. B. Cagan M. D. | 4940 Eastern Avenue | 9/17/49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
| Burial | Sept 28-49 | Mt Calvary | a a Co. Md | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS | |
| 9 19 1949 | Huntington Williams, M.D. | Jennie A. Sayer | 638 N. Gilmor St | |

VS 150

937

232

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78232

TH NO.

Registered No.

NAME OF DECEASED (Type or Print): Price, Thomas Lawrence

2. DATE OF DEATH: 9-17-49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto Co.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Balto.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Randallstown, Md.

Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): Liberty Rd - Reisterstown Road

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | M | May 4 1899 | 50 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10a. KIND OF BUSINESS OR INDUSTRY: Balto Transfer Co.
11. BIRTHPLACE (State or foreign country): Balto County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John A. Price
14. MOTHER'S MAIDEN NAME: Rebecca Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 217-05-5689
17. INFORMANT: Mrs. Ethel Price ADDRESS: Randallstown Md

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? Coronary Occlusion

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Hypertensive C-V disease

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17, 19 49 *to* 9-17, 19 49 *that I last saw the deceased alive on* 9-17-49, 19 ___, *and that death occurred at* 2:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Father Thel M.D. | 23B. ADDRESS: Sinai Hospital of Balto. | 23C. DATE SIGNED: 9-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Sept 19 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Nard's Chapel Cem | 24D. LOCATION (City, town, or county) (State): Balto Co Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Wallis Amoroso | ADDRESS: 4510 Liberty Hgts Ave

937

8233

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 978233

H NO.

1. NAME OF DECEASED (or Print): Bosie M. Venable.

2. DATE OF DEATH: 9-15-1949

PLACE OF DEATH: Baltimore City, Maryland

NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 507 N. Arlington

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-2
d. STREET ADDRESS (If rural, give location): 507 N. Arlington Ave.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | C | married | Feb. 24, 1889 | 60 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter
10. KIND OF BUSINESS OR INDUSTRY: Club

11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Edward Venable

14. MOTHER'S MAIDEN NAME: Louise Rolls.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Martha Venable. ADDRESS: 507 N. Arlington Ave.

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Chronic Cardio. vascular renal disease | 1 1/4 years |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 2, 1938 *to* September 16, 1949 *that I last saw the deceased alive on* 9-14-1949, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John Ed. Camper M. D. | 23B. ADDRESS: 639 N. Carey St | 23C. DATE SIGNED: 9-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9-19-1949 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem. | 24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Mrs. Katie R. Williams & Schroeder | ADDRESS: 1312

VS 150

8234

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

64 Registered No. 078234

TH NO.

NAME OF DECEASED (Type or Print) Jackson, Marie

2 DATE OF DEATH 9/15/49

PLACE OF DEATH: Baltimore City, Maryland 1519 Division St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) President Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02
D STREET ADDRESS (If rural, give location) 1522 Shields Place

Length of stay in Baltimore: Yrs. 1 Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Negro | Single | Oct 21, 1942 | 6 7 | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Baltimore, Md | |

13. FATHER'S NAME —

14 MOTHER'S MAIDEN NAME —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | — | |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma of Thorax

DUE TO

(B) Atelectasis of Left Lung

DUE TO

(C) Emaciation + Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| April 1948 | Lymphosarcoma of Lt Thorax | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 9/10, 1948 to 9/15, 1949 that I last saw the deceased alive on 9/15, 1949, and that death occurred at 4:20 A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr Marcus W. Moore Sr M. D. | President Hospital | 9/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/19/49 | Mt Auburn | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Evangeline Williams M.D. | Les. A. Kelson | 1303 Pennsylvania Ave |

VS 150

55E

8235

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078235

TH NO.

NAME OF DECEASED (Type or Print): Vincent Joseph Naddeo

2. DATE OF DEATH: Sept. 17, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S.Marine Hospital, Balto.,11,Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 342 East Avenue 26-10

Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | May 29, 1919 | 30 | | | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch Repairman
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Joseph Naddeo
14. MOTHER'S MAIDEN NAME: Anna Naddeo - RENZI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 213-28-5958
17. INFORMANT: Records, US Marine Hospital, Balto.,Md. ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adenocarcinoma, right submaxillary gland with generalized metastasis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Duration more than 1 year.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 11, 1949, *to* Sept. 17, 1949 *that I last saw the deceased alive on* Sept. 17, 1949, *and that death occurred at* 5:25 *m., from the causes and on the date stated above.*

23a. SIGNATURE: John L. Wilson, Clinical Director M. D.
23b. ADDRESS: U. S. Marine Hospital, Balto.
23c. DATE SIGNED: 9-17-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept.20 1949
24c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24d. LOCATION (City, town, or county) (State): 4430 Belair Rd. Balt.Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Vecc ADDRESS 322 S. High St.

VS 150

55E

G78236

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78236

TH NO.

NAME OF DECEASED (or Print): JEAN BOWMAN Cox

2. DATE OF DEATH: September 17 1949

PLACE OF DEATH: Baltimore City, Maryland — 525 Washington Blvd.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-03
D. STREET ADDRESS (If rural, give location): 525 Washington Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days / Hours / Min. |
|---|---|---|---|---|---|
| Female | White | Married | June 18 1886 | 63 | |

10A. USUAL OCCUPATION (Give kind of work done most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Martin
14. MOTHER'S MAIDEN NAME: Julia Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-01-1095
17. INFORMANT: Mrs. Wm. R. Hartman — ADDRESS: 117 Grove

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Occlusion | 10 min |
| DUE TO (B) | Hypertensive Cardio Vascular | 4 yrs. |
| DUE TO (C) | Disease. Generalized Arteriosclerosis. | 9 yrs |

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1947, 19__, to Sept 17, 1949 *that I last saw the deceased alive on* Sept 16, 1949 *and that death occurred at* 1:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 642 North Ave
23C. DATE SIGNED: 9-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept-20-49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 19 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: J. A. Grebiauckas Jr.
ADDRESS: 1956 Pratt St

VS 150

937

78237

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78237 Registered No.

H NO.

NAME OF DECEASED (Type or Print): **Matilda E. Walker** 33 ✓

2. DATE OF DEATH: **Sept. 17'49**

PLACE OF DEATH: **Baltimore City, Maryland**

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **2804 Edmondson Ave**

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Md.**
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore** 16-6
D. STREET ADDRESS (If rural, give location): **2804 Edmondson Ave.**

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| | W | Widowed | May 16, 1864 | 85 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Virginia | |

FATHER'S NAME: - Weston

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr Leon Walker- | 2804 Edmondson |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 3 days

(B) Cerebral Sclerosis — DUE TO — 3 years

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 14, 19 49, *to* Sept 17, 19 49 *that I last saw the deceased alive on* Sept 17, 19 49, *and that death occurred at* 5.15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Smendelis M. D. | 651 N Bentalou | 9/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 20'49 | Woodlawn | Woodlawn, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | Harry W. Lyle | 4104 Edmondson Ave |

VS 150

8312

3238

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

151 Registered No. G78238

TH NO.

NAME OF DECEASED (Type or Print): GEORGE W. ROMANS

2. DATE OF DEATH: 9-18-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. AGNES HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-06
D. STREET ADDRESS (If rural, give location): 402 S. Longwood st.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: F. W. ROMANS HERMAN

14. MOTHER'S MAIDEN NAME: ANNA BENTLEY

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Respiratory failure

DUE TO

(B) Atelectasis

DUE TO

(C) Carcinoma Stomach

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/8/49 | Carcinoma Stomach | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 9/1 1949 *to* 9/18, 1949, *that I last saw the deceased alive on* 9/18, 1949, *and that death occurred at* 5:15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank O Dwyer M. D. | St. Agnes Hosp | 9-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT. 21/1949 | LOUDON PARK | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | [illegible] | HARRY H W. TAKE | 4101 EDMONDSON Ave |

VS 150

46B

78239

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

H no. 1 — Registered No. G78239

TH NO.

NAME OF DECEASED (or Print): Catherine Livia Pavone

2. DATE OF DEATH: Sept. 15/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4614 Park Heights Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 27-16
D. STREET ADDRESS (If rural, give location): 4614 Park Heights Ave.

Length of stay in Baltimore: 44 years (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widow | 6-12-1875 | 74 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Genova, Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Carmel Pavone
ADDRESS: 1309 Poplar Grove St

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3½ hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocarditis — 4 yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Obesity.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug. 1949 *to* 9-15, 1949 *that I last saw the deceased alive on* 9-15, 1949, *and that death occurred at* 10:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. L. DeBarbin M. D. | 4723 Park Heights Ave. | Sept 16 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-19-49 | Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | L. V. Lemmon. | 4611 Park Hghts. Ave. |

VS 150

93E

Dr. Peake

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 17°

8240 — H NO. — G78240 — Registered No.

NAME OF DECEASED (Type or Print): Rosa A. Atkins

2. DATE OF DEATH: Sept. 19, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5560 Midwood Avenue

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-48
D. STREET ADDRESS (If rural, give location): 5560 Midwood Avenue

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | widowed | Mar. 23, 1881 | 68 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | New Orleans, La. | |

13. FATHER'S NAME: Michael Conrad

14. MOTHER'S MAIDEN NAME: Sarah ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Miss Rosalie Atkins | 5560 Midwood Ave |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Left Breast — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 3¾ Years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1-19-46 | Carcinoma Left Breast | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1944, 19__, *to* 9-19-, 1949, *that I last saw the deceased alive on* 9-12, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. W. Peake M. D. | 7508 Harford Road | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-22-49 | Elwood Cemetery | Birmingham' Alabama |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 19 1949 | Cunningham Williams, MD | Leonard J. Puck, | 5305 Harford Road |

VS 150

50

8241

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 Registered No. G78241

H NO.

NAME OF DECEASED (or Print) Henry Dentz

2. DATE OF DEATH 9/18/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Memorial Hospital

Length of stay in Baltimore 7 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-2

D. STREET ADDRESS (If rural, give location) 1519 Ronal Hill Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 day) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | 11/8/1867 | 81 82 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber

10a. KIND OF BUSINESS OR INDUSTRY Same

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Adana Dentz

14. MOTHER'S MAIDEN NAME Lucy Ruckel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of prostate - | 9-10 months |
| | DUE TO (B) c metastasis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Generalized Arteriosclerosis | |

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/24/ 1949 *to* 9/18 1949 *that I last saw the deceased alive on* 9/18 1949 *and that death occurred at* 6 35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Herbert L. Lenchos M. D. | 23b. ADDRESS St. Agnes Hospital | 23c. DATE SIGNED 9/18/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 9-21-49 | 24c. NAME OF CEMETERY OR CREMATORY Holy Redeemer | 24d. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 19 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR John A. Moran | ADDRESS 3009 E Balt. St.

VS 150

51B

42 D.O.A

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

17 D.O.D. G78242 Registered No.

H NO.

NAME OF DECEASED (Type or Print): Baby Boy Carroll

2. DATE OF DEATH: Aug. 29, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Carroll

ALL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Greenmount

D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore: Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years last Birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 8/29/49 | 0 0 | | 5 |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Melvin Carroll

14. MOTHER'S MAIDEN NAME: Anna May ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Erythroblastosis foetalis | 3 hrs. |
| DUE TO (B) | CERTIFICATION APPROVED BY | |
| DUE TO (C) | B B Fisher, M. D. CHIEF OR ASST. MEDICAL EXAMINER | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* —— , 19__, *to* —— , 19__, *that I last saw the deceased alive on* —— , 19__, *and that death occurred at* —— *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm H Zuelzer M. D. | JOHNS HOPKINS HOSPITAL | 8/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Hospital Disposal | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 19 1949 | Huntington Williams, M.D. | |

VS 150

Hospital Disposal

161c

643
-130456

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78243

TH NO.

NAME OF DECEASED (or Print): Howard Reynolds

2. DATE OF DEATH: Sept. 3-1949

PLACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): No Home

Length of stay in Baltimore: Life (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| | White | Single | Oct. 4- 1888 | 60 | | | | |

10A. USUAL OCCUPATION (Give kind of one during most of working life, even if retired): Unk

10B. KIND OF BUSINESS OR INDUSTRY: Unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unk (D

14. MOTHER'S MAIDEN NAME: Unk (D

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Baltimore City Hospitals Records: ADDRESS 4940 Eastern Ave.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary emphysema
DUE TO

ANTECEDENT CAUSES

(B)
DUE TO

II. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21- , 1949 to 9-3- , 1949, *that I last saw the deceased alive on* 9-3- , 1949 *and that death occurred at* 11.10 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Cooper M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL SEP 15 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: [redacted]

ADDRESS

VS 150

113

244 — 678244

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 46 1 678244

H NO.

NAME OF DECEASED (or Print): Robert Utter

2. DATE OF DEATH: 9/19/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21 05
D. STREET ADDRESS (If rural, give location): 2223 Wilkens Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | Aug 6, 1888 | 61 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor | Balt City Schools | Baltimore Md | |

13. FATHER'S NAME: George W Utter

14. MOTHER'S MAIDEN NAME: Louisa M Tucker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Margaret M Utter — ADDRESS: 2223 Wilkens Ave

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Anoxemia

DUE TO

(B) Gastro-Intestinal Blood Loss

DUE TO

(C) Esophageal Stricture (Cause unknown)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/17, 1949, to 9/19, 1949, *that I last saw the deceased alive on* 9/19, 1949, *and that death occurred at* 1455 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leon E Kamel M. D. | Sinai Hospital | 9/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/22/49 | London Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | Wilhelm & Son | 1217 E Fayette St |

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245 G78245

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
4 20.1 Registered No.

NO.

NAME OF DECEASED (or Print): HENRY IRA DESMARAIS

2 DATE OF DEATH: Sept. 19, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1100 Brentwood Ave. 10 01

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1100 Brentwood Ave.

Length of stay in Baltimore: 9 years (Yrs. Mos. Days)

SEX: e
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 28, 1889
9. AGE (In years) last birthday: 60
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): binet Maker (RET)
10B. KIND OF BUSINESS OR INDUSTRY: WOODWORKING
11. BIRTHPLACE (State or foreign country): Malone, N.Y.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: Joseph DesMarais
14 MOTHER'S MAIDEN NAME: Elizabeth St.Denis

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: Viola DeSMarais, 1100 Brentwood Ave.

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Coronary occlusion | Sudden |
| DUE TO | | |
| (B) | Cardio vascular disease | — 1945 |
| DUE TO | Hemiplegia | 1945 |
| (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 1949 to 9/19, 1949 that I last saw the deceased alive on 9/19, 1949, and that death occurred at 2-15A m. from the causes and on the date stated above.

23A. SIGNATURE: J.H. MacMurchy M.D.
23B ADDRESS: 801 Bureau St
23C. DATE SIGNED: 9/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 9/21/49
24C. NAME OF CEMETERY OR CREMATORY: Chesterwood
24D. LOCATION (City, town, or county) (State): Reading Pa

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilhelm Colonial Home
ADDRESS: 1217 St Paul St

458 10 931

246

BALTIMORE CITY HEALTH DEPARTMENT 60 G78246

# CERTIFICATE OF DEATH

Registered No.

NO.

NAME OF DECEASED (or Print): Minnie Broughton Chaney

2. DATE OF DEATH: 9/17/49 1:30 P.M.

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2636 Maryland Ave

D. STREET ADDRESS (If rural, give location): 2636 Maryland Ave

Length of stay in Baltimore: Yrs. 1 Mos. Days 7

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 7/22/875 | 74 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Somerset Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Madson

14. MOTHER'S MAIDEN NAME: Susan Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.

17. INFORMANT: Ruth Chaney ADDRESS: 2636 Maryland Ave

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Diabetic Coma | 3 days |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) Diabetes Mellitus. | about 10 yrs |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 25th, 1949, to Sept 17th, 1949, *that I last saw the deceased alive on* Sept 17th, 1949, *and that death occurred at* 1:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Irene McGinnis M.D.
23B. ADDRESS: 28 W 25th St.
23C. DATE SIGNED: Sept. 19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 9/20/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY CASKET REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 217 E. Paul St.

VS 150

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247

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 481°G78247 Registered No.

TH NO.

N-803-4

NAME OF DECEASED (Type or Print): BEULAH WALLACE

2. DATE OF DEATH: September 19, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

Length of stay in Baltimore: 18 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1406 Ashland Avenue 10-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | married | aug 13, 1923 | 26 | | |

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: 000 030
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Whitfield
14. MOTHER'S MAIDEN NAME: Estella Calander

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-07-3167
17. INFORMANT: Lola Fields ADDRESS: 1406 Ashland Ave

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hematoma due to gunshot of head with fractured skull

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9-10-49
19B. MAJOR FINDINGS OF OPERATION: Subdural hematoma
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1406 Ashland Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): September 9, 1949 9.00p.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: [illegible] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/22/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A. A. County

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lothe Gross, 1408 Ashland Ave

151

166

248

M. 128245

# CERTIFICATE CORRECTED 8-26-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. G78248

H NO.

| | |
|---|---|
| AME OF DECEASED (or Print) **Charles Bien** | 2. DATE OF DEATH **Sept. 18, 1949** |
| ACE OF DEATH: **altimore City, Maryland** | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY **Baltimore** |
| LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.** | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** ESSEX |
| ength of stay in Baltimore **Life** Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) **534 Riverside Drive** |

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **ale** | **White** | **Single** | **Jan. 23, 1948** | **40 (15 MOS.** | | |

| USUAL OCCUPATION (Give kind of one during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | **Maryland** | |

| ATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| **Richard Bien.** | **Helen Bauer** |

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | **B.C.H. Records** | **4940 Eastern Ave.** |

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Hydrocephalus , Congenital**

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* **4-13-** *, 19* **49** *to* **9-18-** *, 19* **49** *that I last saw the deceased alive on* **9-18-** *19* **49** *and that death occurred at* **5.15** P *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| **M. D.** | **4940 Eastern Ave** | **Sept. 19, 49** |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Sept. 20-49** | **Western Cemetery** | **Balto Md** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| **SEP 20 1949** | **Huntington Williams, M.D.** | **John F. Connelly** | **418 Eastern Ave** |

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157a Balto 31, Md

249

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

571-678249 Registered No.

TH NO.

NAME OF DECEASED (or Print) Roland Baker

2. DATE OF DEATH Sept 17 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) County Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Eng.

Length of stay in Baltimore Yrs. 0 Mos. Days

D. STREET ADDRESS (If rural, give location) Middleburgh - St Georges Rd

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | W. | single | | 1 yr. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Md. | U.S.A. |

13. FATHER'S NAME George Baker

14. MOTHER'S MAIDEN NAME Ellen Eaton ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No / No | None | Father | (Same address) |

## CAUSE OF DEATH

18.

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Streptococcic cardiac + DUE TO dehydration following

(B) empyema Diarrhea DUE TO

(C) Bilateral atelectasis pulmonal.

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 20 days.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 6:00 Am 9/17/49, to 8:45 Am 9/17/49, *that I last saw the deceased alive on* 9/17/49 8:30 Am 19, *and that death occurred at* 8:41 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. O. Monfara, M.D. M. D. | County Hosp. | 9/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 20-49 | Mt. Zion Cem | Harford Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | John S. Connelly | 418 Eastern Ave. |

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1190 Balto 21 Md.

250

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 G78250

Registered No.

H NO.

NAME OF DECEASED (or Print): William Ernest Wright

2. DATE OF DEATH: 9/17/49

PLACE OF DEATH: Baltimore City, Maryland

3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 1906 N. Broadway

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp

Length of stay in Baltimore: 35 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | Jan 9 1881 | 68 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10a. KIND OF BUSINESS OR INDUSTRY: ODD JOBS
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: John Wright
14. MOTHER'S MAIDEN NAME: Annie Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp. records ADDRESS:

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular hemorrhage
DUE TO
(B) Arteriosclerosis & hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/17, 1949 *to* 9/17, 1949 *that I last saw the deceased alive on* 9/17, 1949 *and that death occurred at* 2:40 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Sliwinski M. D.
23B. ADDRESS: St. Joseph's Hosp.
23C. DATE SIGNED: 9/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/21/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or County) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Payson Sanders ADDRESS: 832 1412 E Preston St

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8251 — BALTIMORE CITY HEALTH DEPARTMENT — G78251

# CERTIFICATE OF DEATH

151 — Registered No.

H NO.

NAME OF DECEASED (or Print): Mary C. Barnes — 2. DATE OF DEATH: Sept 17-49

PLACE OF DEATH: Baltimore City, Maryland — Balto

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2812 Clifton Park Terr

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY: 2812 Clifton Park Terrace — Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location)

Length of stay in Baltimore: Life — Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| | W | Widowed | March 29-1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto | |

FATHER'S NAME: Wm J. Swirk

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Wm Barnes | 2812 Clifton Pk. Terr |

## CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Cardiovascular Heart Disease — several years

DUE TO

(C)

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 16 to 9-16 49, *that I last saw the deceased alive on* 9-16 49, *and that death occurred at* 5.45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William E. Deaver M. D. | 3025 Edgar Road | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 21-49 | Holy Redeemer | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | Jos J Stern & Son | 3001 Centrally ave |

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252

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78252

TH NO.

NAME OF DECEASED (Type or Print): Harry P. O'Neil

2. DATE OF DEATH: Sept 19th 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION: 311 E. West St (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 311 E. West St

SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12/27/1899
9. AGE (In years last birthday): 49 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ele Driver
10a. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Harry W. O'Neil
14. MOTHER'S MAIDEN NAME: Mary A O'Brien
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-03-7056
17. INFORMANT: Margaret A. O'Neil
ADDRESS: 311 East West St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William E. Helfrich M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 9/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/22/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Balto Co Md
25. FUNERAL DIRECTOR: Robt C. & B. M. Walter Robert E. Streifthau

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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G78253

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Lloyd Crosby

2. DATE OF DEATH: Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland — Balto. City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

Length of stay in Baltimore: 13 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 18 N. Bond St. 6-05

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | S | Feb. 9. 1915 | 34 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Contractor | Chester S.C. | U.S.A. |

FATHER'S NAME: James Crosby

14. MOTHER'S MAIDEN NAME: Mamie Thomas

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Millie Mae Crosby | 1115 W. Catherin St Richmond Va |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Tuberculosis | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. J. Mc Dafferty M.D. | | Sept. 16, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | SePt.22.49 | Piney Grove Cem. | Chester S.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.C. | Elroy O. Wilson | 1000 Brantly Ave |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

TH NO. Registered No. G78254

NAME OF DECEASED (Type or Print) JOHN G. TAYLOR

2. DATE OF DEATH 9-19-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

Length of stay in Baltimore MANY YEARS Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 707 BERRY AVE 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | 6/19/96 | 53 | 33 | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER
10B. KIND OF BUSINESS OR INDUSTRY RAILROAD
11. BIRTHPLACE (State or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO
17. INFORMANT MRS LITTIE THAYER ADDRESS 707 BERRY AVE.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY OCCLUSION
DUE TO
(B) ARTERIO SCLEROSIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* SEPT 15, 1949, *to* SEPT 19, 1949, *that I last saw the deceased alive on* SEPT 19, 1949, *and that death occurred at* 6:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles N. Wolff, M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 9/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/22/49
24C. NAME OF CEMETERY OR CREMATORY Pine Grove
24D. LOCATION (City, town, or county) (State) Delta Pa.

DATE RECEIVED BY LOCAL REGISTRAR SEP 20 1949
REGISTRAR'S SIGNATURE Hunter Williams, M.D.
25. FUNERAL DIRECTOR Paul E. Lebenomette Jr. ADDRESS 3615-17 Eastern Ave

VS 150

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78255 — Registered No. 157

2255 — H NO.

NAME OF DECEASED (Type or Print): Elizabeth Buchman

2 DATE OF DEATH: 9-20-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3502 Buena Vista - 13-0 6

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Dec 23, 1879 | 69 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham Williams
14. MOTHER'S MAIDEN NAME: Harriet White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service): —
16. SOCIAL SECURITY NO.: —

17. INFORMANT: Wm D. Buchman — ADDRESS: 3502 Buena Vista

## 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Carcinoma - Probably of
DUE TO Cervix with multiple
(B) metastases.
DUE TO Terminal Anuria.
(C)

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10, 1949, *to* 9-20, 1949, *that I last saw the deceased alive on* 9-20, 1949, *and that death occurred at* 1:35 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| K. G. Smith Jr. M. D. | Univ. Hosp. | 9-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 22/49 | St Mary's | Hampden |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949 — REGISTRAR'S SIGNATURE: Hunter for Williams, M.D. — 25. FUNERAL DIRECTOR: Paul E. Schwartzbek — ADDRESS: 36 S. Paca St.

VS 150

469

78256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 78256

H NO.

AME OF DECEASED (or Print): Mrs. Marie Anna Krause

2. DATE OF DEATH: September 19, 1949

LACE OF DEATH: altimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

ength of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3419 Mt. Pleasant Avenue 26 08

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| e. | White | Widowed | 5/18/00 | 49 3 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Matron | Police Dept. | Baltimore, Maryland | U.S.A. |

FATHER'S NAME: ? Reuter

14 MOTHER'S MAIDEN NAME: ? ?

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | | Michael Krause | 3419 Mt Pleasant Ave |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of pleura, right
DUE TO metastatic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/2/49, 19__, *to* 9/19/, 1949, *that I last saw the deceased alive on* 9/19/, 1949, *and that death occurred at* 8:45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maddena Siwinski M. D. | 1400 N. Caroline Street | 9/19/49 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/22/49 | Oak Lawn | Balto Md. |

DATE RECEIVED BY REGISTRAR: Sept 19 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: Foley & Sons — ADDRESS: 413 S. Wolfe St

VS 150

47E

2:57

43481

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 G782557 Registered No.

H NO.

| | |
|---|---|
| AME OF DECEASED (or Print) James Ward. | 2. DATE OF DEATH Sept. 19, 1949 |
| LACE OF DEATH: altimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore |
| ength of stay in Baltimore Yrs. Life Mos. Days | D. STREET ADDRESS (If rural, give location) B.C.H. 4940 Eastern Ave. 26 17 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Seperated | ? | 66 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mark | Mark | Maryland | U. S. Cr |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? | ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B.C.H. Records | 4940 Eastern Ave |

## 18. CAUSE OF DEATH

| | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Broncho Pneumonia | |
| DUE TO (B) Hypertensive Cardio Vascular Disease. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) Old Right Hemiplegia | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 4-2-39, 19__, *to* 9-19-, 19 49 *that I last saw the deceased alive on* 9-19 19 49 *and that death occurred at* 2.30A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. B. Cozen M. D. | 4940 Eastern Ave. | Sept. 19, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/22/49 | Cedar Hill - | Balto - Co - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Lustington Williams, M.D. | Selby + Zeiler | 403 S. Wolfe St |

VS 150

93D

G78258

ES-131929
H NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

| | |
|---|---|
| AME OF DECEASED (or Print) Harry Taylor | 2. DATE OF DEATH 9-17-49 |
| LACE OF DEATH: altimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY |
| ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto |
| ength of stay in Baltimore Life (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location) 2007 Casadel Avenue, Morrell Park |
| EX le / 6. COLOR OR RACE White / 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH July 14, 1884 / 9. AGE (In years last birthday) 65 / If under 1 year: Months, Days / If under 24 hours: Hours, Min. |
| USUAL OCCUPATION (Give kind of one during most of working life, even if retired) ON MOLDER | 10B. KIND OF BUSINESS OR INDUSTRY Koppers Co. |
| 11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY? |
| FATHER'S NAME Lewis Casodel (Cassadell) | 14. MOTHER'S MAIDEN NAME Isabel Potter |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO 212-09-8899 |
| 17. INFORMANT | ADDRESS 4940 RECORDS BALTO. CITY HOSPITALS EASTERN AVE. |

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Vascular Accident | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Hypertensive arteriosclerotic Cardiovascular Disease | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Probable Silicosis | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 9-17 *, 19* 49 *to* 9-17 *, 19* 49 *, that I last saw the deceased alive on* 9-17 *, 19* 49 *and that death occurred at* 7:15 P *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE A. L. Rogers M. D. | 23B. ADDRESS 4940 Eastern Avenue | 23C. DATE SIGNED 9-17-49 |
| A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept 21/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park |
| 24D. LOCATION (City, town, or county) (State) BALTO. MD. | | |
| ATE RECEIVED BY CAL REGISTRAR SEP 20 1949 | REGISTRAR'S SIGNATURE Tuntington Williams, M.D. | 25. FUNERAL DIRECTOR Henry H. Withe |
| ADDRESS 4101 E Monument Ave. | | |

VS 150

TO BE APPROVED BY MEDICAL EXAMINER

9-20

2:59 N-T BALTIMORE CITY HEALTH DEPARTMENT 491 K G782259 Registered No.

# CERTIFICATE OF DEATH

**PLACE OF DEATH:**
1. Baltimore City, Maryland
Street address 3049 Weaver Ave
Hospital or institution: at Home
Length of stay in hospital or inst. (yrs., mos., or days) —
Length of stay in Baltimore (yrs., mos., or days) 80 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3049 Weaver Ave (If rural give location)
27 or
(e) If foreign born, how long in U. S. A.? U.S. years

(a) FULL NAME Virginia Nichols Morgan.

(b) If veteran, name war: none
3 (c) Social Security Account No. none

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

(b) Name of husband or wife: William James Morgan
6 (c) If alive, give age — years

Birth date of deceased (mo., day, yr.) Sept 17, 1859

AGE: Years 90 | Months 0 | Days 6 | If less than one day: hr. min.

4. Birthplace Somerset Co, Md. (Town, county, and state)
10. Usual Occupation Hsw
11. Industry or business

12. Name Littleton H. Pusey
13. Birthplace Somerset Co, Md.
14. Maiden Name Eliza M. Richards
15. Birthplace Somerset Co, Md.

16 (a) Informant Emma E. Morgan
(b) Address 3049 Weaver Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Stewart Memorial Co.
(b) Address 108 W North Ave,

19 SEP 20 1949 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 18 1949, at 1 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938 to Sept 18 1949. and that I last saw her alive on Sept 17 1949.

Immediate cause of death: Bronchopneumonia — Duration 9 16 49
Due to Uremic Coma — 9 17 49
Due to Senility — 9 18 49
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter L. Barlow M.D.
Address 4731 Harford Rd Date signed 9/18/49

VS 3

107

78260

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 974.7 078260 Registered No.

H NO.

1. NAME OF DECEASED (Type or Print): Prince E. Elliott. N-991

2. DATE OF DEATH: Sept. 18th 1949

PLACE OF DEATH: Baltimore City, Maryland Southern Police Station

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: Anna Arundel Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Pasadena
D. STREET ADDRESS (If rural, give location): Pasadena Md

SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 18th 1904
9. AGE (In years last birthday): 45 44
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: George R Ellt.
14. MOTHER'S MAIDEN NAME: Minnie McClellan

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-07-4558
17. INFORMANT: Veloris A Elliott ADDRESS: Pasadena Md

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Strangulation
DUE TO
(B) Hanging
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): Police Cell
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Southern Police Station
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): September 18, 1949 5:30A.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by belt attached to cell bars

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Ryan M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Sept 18 1949

26A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 21st 1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo G. Leach ADDRESS: 1703 Patterson Park Ave

164a

8261

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078261

H NO.

NAME OF DECEASED (or Print) ALMA McCRUDEN

2. DATE OF DEATH 9/18/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4636 PALL MALL RD

Length of stay in Baltimore — Yrs. Mos. Days

SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W | 8. DATE OF BIRTH 6/14/04 | 9. AGE (In years last birthday) 45 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Accountant | 10b. KIND OF BUSINESS OR INDUSTRY State Welfare | 11. BIRTHPLACE (State or foreign country) Baltimore Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edwin Shoop | 14. MOTHER'S MAIDEN NAME Anna Reiter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) — (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mr. Nicholas Shoop ADDRESS 542 Longwood Ave

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral malacia
DUE TO
(B) Thrombosis left int. carotid
DUE TO
(C) (Hypertension ?)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/17, 1949 to 9/18, 1949 that I last saw the deceased alive on 9/18, 1949, and that death occurred at 11:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE Wallace Graham M.D. | 23B. ADDRESS Sinai Hospital | 23C. DATE SIGNED 9/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept 21/49 | 24C. NAME OF CEMETERY OR CREMATORY DRUID RIDGE, | 24D. LOCATION (City, town, or county) (State) Pikesville MD BALTO. CO MD.

DATE RECEIVED BY LOCAL REGISTRAR SEP 20 1949 | REGISTRAR'S SIGNATURE Courtenay for Williams, M.D. | 25. FUNERAL DIRECTOR Loring Byers ADDRESS 5005 Ph Hgts Ave

99

262 BALTIMORE CITY HEALTH DEPARTMENT G78262
# CERTIFICATE OF DEATH
Registered No.

TH NO.

NAME OF DECEASED (or Print): CHARLES FREDERICK KAHMER

2. DATE OF DEATH: Sept. 20, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3916 Fleetwood Avenue

D. STREET ADDRESS (If rural, give location): 3916 Fleetwood Avenue

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | Oct. 4, 1874 | 74 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bricklayer | BLDG. CONST | Baltimore, Md. | USA |

13. FATHER'S NAME: Philip Kahmer

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 213-10-2435

17. INFORMANT: Mrs. Anna I. Beatty, 3916 Fleetwood Avenue

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 day |
| DUE TO (B) | Arteriosclerosis, Coronary | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertension, arterial | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 19, 1949 *to* Sept 20, 1949 *that I last saw the deceased alive on* Sept 19, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles V. Wright M. D.
23B. ADDRESS: 1 W. Overlea Ave
23C. DATE SIGNED: 9/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/23/49
24C. NAME OF CEMETERY OR CREMATORY: OakLawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Thurlow Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS:

VS 150

BALTIMORE - 13, MARYLAND 94a

8263

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 1 Registered No. 78263

H NO.

1. NAME OF DECEASED (or Print) Andrew John Pullen

2. DATE OF DEATH Sept. 17-1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B COUNTY
1704 E. Monument St. 1

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location) 1704 E. Monument St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md

ength of stay in Baltimore 87 Yrs. 2 Mos. Days

D. STREET ADDRESS (If rural, give location) 1704 E. Monument St

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year Months | Days | If under 24 hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | widowed | June 15. 1862 | 87 | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stone mason | Memorial business | Balto. Md. | U.S.A. |

ATHER'S NAME George Pullen

14. MOTHER'S MAIDEN NAME Barbara Fravnhootz

| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Anna Pullen | 1704 E. Monument St |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | Sept 14 49 |
| DUE TO (B) | Generalized Arteriosclerosis | 15 years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* September 1948, to Sept. 1949 *that I last saw the deceased alive on* Sept 15, 1949 *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chalmers Stewart M. D. | 6 E. Read St | Sept 17-49 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/21/49 | New Cathdral Cemetery | Baltimore, Md. |

| TE RECEIVED BY CAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. |

VS 150

BALTIMORE - 13, MD.

83a

3264 ✓ X 2001 G78264

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

NO.

NAME OF DECEASED (or Print) ROBERT Young

2. DATE OF DEATH 9/19/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenburnie
D. STREET ADDRESS (If rural, give location) Marley Park

Length of stay in Baltimore: Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | | 1917 | 32 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer Installation
10a. KIND OF BUSINESS OR INDUSTRY TELEVISION
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME Mary Repath
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Wife ADDRESS

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acidosis, Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Leukosarcoma

DUE TO (C) Lymphosarcoma

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/8, 1949, to 9/19, 1949, *that I last saw the deceased alive on* 9/19, 1949, *and that death occurred at* 8:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE Nicholas Mallis M. D.
23B. ADDRESS Univ. Hosp
23C. DATE SIGNED 9/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Sept 23
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Balto Co

DATE RECEIVED BY LOCAL REGISTRAR SEP 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wheeler Funeral Home ADDRESS 2008 Oakleigh

VS 150 55E

8265

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. E 9763 078265
EN-8 51.7

TH NO.

NAME OF DECEASED (Type or Print): THOMAS HOFFERBURTH

2. DATE OF DEATH: September 19, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~142~~ Balto
D. STREET ADDRESS (If rural, give location): 1243 N Broadway 8 07

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Feb 28 1882 | 67 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Pattern Maker
10B. KIND OF BUSINESS OR INDUSTRY: Navy Yard
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Sam Hoffenbuth
14. MOTHER'S MAIDEN NAME: Philahelmia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Dora Hoffenbuth ADDRESS: 1243 Broadway

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of brain
DUE TO Terminal bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Yard
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Mayo, Maryland
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 6, 1949 7:15 P. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 9-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 22/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Balto Co
25. FUNERAL DIRECTOR: Ullman Funeral Home ADDRESS: 2008 Pleasant

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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78266

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

175 Registered No. G78266

H NO.

| | |
|---|---|
| NAME OF DECEASED (or Print) | MARGARET ALICE ELIASON |
| 2. DATE OF DEATH | Sept. 18, 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | 4314 Berger Ave. |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 2323 E. Madison St. 7-03 |
| Length of stay in Baltimore (Yrs. Mos. Days) | life |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Aug. 18, 1894 |
| 9. AGE (In years last birthday) (If under 1 year: Months / Days; If under 24 hours: Hours / Min.) | 55 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 13. FATHER'S NAME | Timothy Dailey |
| 14. MOTHER'S MAIDEN NAME | Anna Lanahan |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT ADDRESS | James E. Eliason, Jr., 2323 E. Madison St. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of ovary | 1 year |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | Dec. 7, 1948 | |
| 19B. MAJOR FINDINGS OF OPERATION | Carcinoma of Ovary | |
| 20. AUTOPSY? YES ☐ NO ☐ | | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | | |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | | |
| 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | | |
| 21F. HOW DID INJURY OCCUR? | | |

22. *I hereby certify that I attended the deceased from* Oct. 10, 1948 *to* Sept 18, 1949 *that I last saw the deceased alive on* Sept 17, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

| | | | |
|---|---|---|---|
| 23A. SIGNATURE | Joseph Pokorny M. D. | 23B. ADDRESS | 2200 E Madison St |
| 23C. DATE SIGNED | 9/19/49 | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 24B. DATE | 9/22/49 |
| 24C. NAME OF CEMETERY OR CREMATORY | New Cathedral Cemetery | 24D. LOCATION (City, town, or county) (State) | 4300 Old Frederick Rd. |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 20 1949 | REGISTRAR'S SIGNATURE | Huntington Williams, M.D. |
| 25. FUNERAL DIRECTOR ADDRESS | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. | | |

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G78267

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78267

H NO.

| | |
|---|---|
| AME OF DECEASED or Print) | ANNA KRUCKY |
| 2. DATE OF DEATH | Sept. 18, 1949 |
| LACE OF DEATH: altimore City, Maryland | 2445 E. Eager St. |
| ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 2445 E. Eager St. |
| ength of stay in Baltimore (Yrs. Mos. Days) | 64 years |
| EX | Female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widowed |
| 8. DATE OF BIRTH | May 1, 1861 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min. | 88 |
| USUAL OCCUPATION (Give kind of ne during most of working life, even if retired) | housewife |
| 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Czechoslovakia |
| 12. CITIZEN OF WHAT COUNTRY? | |
| FATHER'S NAME | John Ledvina |
| 14. MOTHER'S MAIDEN NAME | unknown |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT ADDRESS | Mrs. Lillian E. Cummings, 2445 E. Eager St. |

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Generalized Arteriosclerosis | ? |
| DUE TO (B) | Myocardial degeneration | 3 mo. |
| DUE TO (C) | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Sept 3, 1949 *to* Sept 17, 1949 *that I last saw the deceased alive on* Sept 17, 1949, *and that death occurred at* 8:15 p m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE M. D. | Louis J. Klimas | |
| 23B. ADDRESS | 2623 E. Monument St | |
| 23C. DATE SIGNED | 9/19/49 | |
| A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 9/21/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) | 4430 Belair Rd. Baltimore | |
| TE RECEIVED BY CAL REGISTRAR | SEP 20 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, M.D. | |
| 25. FUNERAL DIRECTOR ADDRESS | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. | |

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937

268 MS 131935 CERTIFICATE CORRECTED 8-24-50

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78268

H NO.

NAME OF DECEASED (or Print) Reed Shaw

2. DATE OF DEATH Sept. 17, 1949

PLACE OF DEATH: altimore City, Maryland

LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

ength of stay in Baltimore 51 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 769 Carroll Island RD. Box ~~759~~ RT. 14 Chase, Md.

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| e | White | Widowed | Nov. 25, 1896 | 52 | | |

| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | PA. | |

FATHER'S NAME: Silas Shaw

14. MOTHER'S MAIDEN NAME: Jeannette Ziegler

| WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B.C.H. RECORDS | 4940 Eastern Ave. |

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myrocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-17 , 1949 *to* 9-17- , 1949, *that I last saw the deceased alive on* 9-17 , 1949, *and that death occurred at* 8:55 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Cogen M. D. | 4940 Eastern Ave. | 9-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24C. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 21-49 | Sacred Heart | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25A. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | John F. Connelly | 418 Eastern Ave Balto 2 Md |

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER 94a

18929

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78269

NAME OF DECEASED (Type or Print): Eli, Tuppence

2. DATE OF DEATH: Sept. 18, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mary land
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 801 Druid Hill Ave.

Length of stay in Baltimore: Since 1928 (Yrs. / Mos. / Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| le | Negro | Single | 6-4-1872 | 77 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Tuppence
14. MOTHER'S MAIDEN NAME: Amelia Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B.C.H. Records 4940 Eastern Ave. ADDRESS:

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertensive Heart Disease. | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-23-36, 19__, *to* 9-18-, 19 49 *that I last saw the deceased alive on* 9-18-, 19 49 *and that death occurred at* 9.10 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 9-19-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/21/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 20 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918 Druid Hill Ave.

VS 150

93D

270 BALTIMORE CITY HEALTH DEPARTMENT 17° G78270
H NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (or Print): Ora Willing Penniman
2. DATE OF DEATH: Sept 19, 1949
PLACE OF DEATH: Baltimore City, Maryland Med. Mby 3
ALL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Govans Forge
D. STREET ADDRESS (If rural, give location): 604 Murdock Road
Length of stay in Baltimore: 23 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 7-16-92 | 57 yrs. | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Irvington, Virginia | |

13. FATHER'S NAME: Thomas J. Willing
14. MOTHER'S MAIDEN NAME: Sarah Messick

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | | JOHNS HOPKINS HOSPITAL |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinomatosis | 11 Mo |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Carcinoma of Breast | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/14/49 | Carcinomatosis | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-3-49, *to* 9-19-49, *that I last saw the deceased alive on* 9-19-49, *and that death occurred at* 4:12 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas N P Johns M. D. | JOHNS HOPKINS HOSPITAL | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/22/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 20 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

50

BS-88993 or 88994

8271

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 678271

NAME OF DECEASED (Type or Print) John Kline

2. DATE OF DEATH 9-18-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) City Hospitals

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Wid | Sept. 30, 1860 | 88 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Saloon-keeper(rtd) | Own Business | Md (Baltimore) | |

13. FATHER'S NAME Lenhardt Kline

14. MOTHER'S MAIDEN NAME Marie Keil

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Heart Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Broncho Pneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 7-14, 1944 *to* 9-18, 1949, *that I last saw the deceased alive on* 9-18 1949, *and that death occurred at* 12:05 A. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 4940 Eastern Avenue | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/21/49 | Schwartz Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 20 1949 | Lucretia Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150 ~~TO BE APPROVED BY MEDICAL EXAMINER~~

93D

272 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G78272

# CERTIFICATE OF DEATH

F 97-0

TH NO. N-9680

NAME OF DECEASED (Type or Print): JOHN EDWARD MASHMEYER

2. DATE OF DEATH: September 19, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2962 Harford Road

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| ale | White | Married | June 14, 1923 | 26 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber | Howard Plumbing | Baltimore, Maryland | |

13. FATHER'S NAME: John Mashmeyer

14. MOTHER'S MAIDEN NAME: Jane M. Glennen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Elizabeth J. Mashmeyer ADDRESS: 2962 Harford Road

## 18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO Carbon monoxide

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 2962 Harford Road |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| September 19, 1949 ? P.M. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | (Illuminating gas) Oven and four burners on but unlit |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| PER: RS Fisher JOHN H. DAVIS, M.D. M.D. | ☒ | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-22-49 | Baltimore National | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Sep 20 1949 | Hunter for Williams, MD | Leonard J. Ruck | 5305 Harford Road |

151

163H

CERTIFICATE CORRECTED 9/27/49

G78273

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

451 Registered No.

NO.

NAME OF DECEASED (or Print) George Snowman

2. DATE OF DEATH 9/19/49

PLACE OF DEATH: Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital of Baltimore

D. STREET ADDRESS (If rural, give location) 4623 Kenwood Ave. 27 11

Length of stay in Baltimore 72 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Sept. 27, 1877 1876 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Salesman

10B. KIND OF BUSINESS OR INDUSTRY Retired 15 yrs

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick Snowman

14. MOTHER'S MAIDEN NAME Josephine Kuber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Mabel Snowman ADDRESS 4655 Kenwood Ave

## CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

**ANTECEDENT CAUSES**

(B) Dissecting Aneurysm Aorta

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

DUE TO

(C)

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive CVD

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/10, 1949 *to* 9/19, 1949 *that I last saw the deceased alive on* 9/19, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Max J Miller M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 9/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-22-49

24C. NAME OF CEMETERY OR CREMATORY Medow Ridge

24D. LOCATION (City, town, or county) Washington Blvd (State) Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John C. Moran ADDRESS 3000 Balt. St.

VS 150

30D

G78274

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G78274

H NO.

| | |
|---|---|
| NAME OF DECEASED (or Print) | MARY JANE BENNETT |
| 2. DATE OF DEATH | Sept. 19, 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2931 Guilford Ave. |
| D. STREET ADDRESS (If rural, give location) | 2931 Guilford Ave. 12-02 |
| Length of stay in Baltimore (Yrs. Mos. Days) | |
| SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widowed |
| 8. DATE OF BIRTH | Feb. 19, 1858 |
| 9. AGE (In years last birthday) (If under 1 year: Months, Days; If under 24 hours: Hours, Min.) | 91 yrs. |
| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Housewife (retired) |
| 10b. KIND OF BUSINESS OR INDUSTRY | Home |
| 11. BIRTHPLACE (State or foreign country) | Talbot Co., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| FATHER'S NAME | William Collison |
| 14. MOTHER'S MAIDEN NAME | Martha Fooks |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT | Mr. Hollis F. Bennett |
| ADDRESS | 236 Franklintown Rd. |

## CAUSE OF DEATH

18.

I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Myocardial Degeneration. | Several Years. |
| DUE TO | | |
| (B) | Hypertension - Senility | Several Years. |
| DUE TO | | |
| (C) | | |

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* February 1948 *to* Sept. 19 1949, *that I last saw the deceased alive on* Sept. 17, 1949, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | W. Hoffman, M. D. M. D. | |
| 23B. ADDRESS | 8 East Read Street | |
| 23C. DATE SIGNED | 9/20/49 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 9/21/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Methodist Protestant | |
| 24D. LOCATION (City, town, or county) (State) | Sharptown, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 20 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, M.D. | |
| 25. FUNERAL DIRECTOR | WM. J. TICKNER & SONS | |
| ADDRESS | Balto., Md. | |

VS 150

93D

CERTIFICATE CORRECTED 9-22-49

275 BALTIMORE CITY HEALTH DEPARTMENT E 98 ° G78275

TH NO. **CERTIFICATE OF DEATH** Registered No.

AME OF DECEASED (or Print) ROBERT LEWIS NEWSON N-861-1 | 2. DATE OF DEATH August 13, 1949

LACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01
D. STREET ADDRESS (If rural, give location) 1369 N. Carey Street

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) Provident Hospital

ength of stay in Baltimore Yrs. Mos. Days

| EX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| le | colored | Married | | 35 | | |

| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | None | North Carolina | |

| FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Marvin Newsom | Bessie Sykes |

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | X | Marvin Newsom | Seabord, N. C. |

18. **CAUSE OF DEATH**

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stab wound of heart
DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.
(B)
DUE TO
(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 1369 N. Carey Street |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| August 13, 1949 2.00p.m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Sharp instrument |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

| 23a. SIGNATURE | 23b CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23c. DATE SIGNED |
|---|---|---|
| William J. McClafferty M.D. | | August 15, 1949 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Aug. 16, 1949 | | Conway N.C. |

| TE RECEIVED BY CAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| EP 20 1949 | Huntington Williams, M.D. | William W. Bridgers | Conway, North Carolina |

151

167

276 ✓ G78276

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No.

H NO.

1. NAME OF DECEASED (Type or Print): Joseph Hannewald HANNEWALD — 2. DATE OF DEATH: 9/20/49

3. PLACE OF DEATH: Baltimore City, Maryland Balto. Md.
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 819 W. Barre St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept 10, 1896 | 53 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Minister | Church | Md. | |

13. FATHER'S NAME: Martin Hannewald
14. MOTHER'S MAIDEN NAME: Catherine Metzger

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs. Joseph Hannewald | 819 W. Barre St |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CIRCULATORY COLLAPSE

DUE TO

(B) CORONARY ARTERY OCCLUSION

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/20, 1949 *to* 9/20, 1949 *that I last saw the deceased alive on* 9/20, 1949, *and that death occurred at* 1°5 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel P. Scalia M. D. | 1213 Light Street | 9/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/23/49 | Balto | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 217 St. Paul St |

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8277 ✓ G78277

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 3 30

H NO. Registered No.

NAME OF DECEASED (or Print) MARY C. RUSSELL

2. DATE OF DEATH SEPT 20 49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1657 BALTO GEN HOSP.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-04
D. STREET ADDRESS (If rural, give location) 1448 Harlem Ave

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Divorced | 4/16/1905 | 44 | 5 | 4 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Va. | |

FATHER'S NAME Clarence Barrett

14. MOTHER'S MAIDEN NAME Unknown

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Shirley A. Nickels | 1448 Harlem Ave. |

## 18. CAUSE OF DEATH

| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I (A) | SUBARACHNOID HEMORRHAGE | |
| DUE TO (B) | HYPERTENSION | |
| DUE TO (C) | | |
| II | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 9/19/49 *to* 9/20/49, *that I last saw the deceased alive on* 9/19/49, *and that death occurred at* 2:25 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. R. Gombek M. D. | WBGH | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/23/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | ~~Irving Williams, M.D.~~ | Wm Cook Inc. | 1217 St. Paul St |

VS 150 Gohombek 83a

278 CERTIFICATE CORRECTED 9-21-49 G78278

ES-131927 BALTIMORE CITY HEALTH DEPARTMENT

TH NO. CERTIFICATE OF DEATH Registered No.

NAME OF DECEASED (or Print) Vincent Trzcinski

2. DATE OF DEATH 9-19-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 2-02
D. STREET ADDRESS (If rural, give location) 1828 Gough Street.

Length of stay in Baltimore: 43 Yrs. (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 3, 1885 | 64 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | U.S. Coast Guard | Poland | |

13. FATHER'S NAME: Vincent Trzcinski

14. MOTHER'S MAIDEN NAME: Catherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service)

16. SOCIAL SECURITY NO. 219-01-6280

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Heart Disease. | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | DUE TO (C) Broncho Pneumonia Broniectasis Pulmonary Tuberculosis Anemia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-17, 1949, *to* 9-19, 1949 *that I last saw the deceased alive on* 9-19, 1949, *and that death occurred at* 10:50 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. A. Logan M. D. | 4940 Eastern Avenue | 9-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/22/49 | St. Stanislaus | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | Wm Cook Jr. | 1217 St. Paul St |

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279

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78279

H NO. B.C. 49-17058

AME OF DECEASED (or Print) Lamont BRYANT

2. DATE OF DEATH Sep 10 1949

LACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 22-02
D. STREET ADDRESS (If rural, give location) 649 W. Lee St.

LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) University Hospital

ength of stay in Baltimore 24 days (Yrs. Mos. Days)

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| ale | black | single | Aug 17 1949 | | 24 | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME | 14. MOTHER'S MAIDEN NAME

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS

## CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart block — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Hypocalcemia — 24-36 hrs

DUE TO

(C) diarrhea — 4-5 days

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sep 9, 1949, *to* Sep 10, 1949, *that I last saw the deceased alive on* Sep 10, 1949, *and that death occurred at* 10:45 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. J. Broaddus M. D. | University Hospital | Sep 10 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | SEP 15 1949 |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. SIGNATURE OF FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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6-5 G78280

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

1. NAME OF DECEASED (Type or Print): MACKLIN, Baby Girl

2. DATE OF DEATH: 9-4-49

PLACE OF DEATH: Baltimore City, Maryland — Balto. Md.

ALL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. of Md. Hosp

Length of stay in Baltimore: Yrs. — Mos. — Days 7

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore City — Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk — AVON BEACH 18
D. STREET ADDRESS (If rural, give location): 158 Avonbrook Rd #22

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | B | Baby | 8-29-49 | 0 | 0 / 6 | — / — |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| baby | baby | Md | U.S. |

13. FATHER'S NAME: Horace Glenford Newton

14. MOTHER'S MAIDEN NAME: Ronnie Macklin

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | — | — | Mother | 158 Avonbrook Rd AVON BEACH 18 |

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital atelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) prematurity — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-29, 1949, *to* 9-4, 1949, *that I last saw the deceased alive on* 9-4, 1949, *and that death occurred at* 10:50 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Abstracts Bn M. D. | U of Md. Hosp | 9-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | SEP 15 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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G78281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78281

H NO. B.C. 49-16926

1. NAME OF DECEASED (Type or Print): Baby of Ruth Gillis

2. DATE OF DEATH: 8/15/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital

Length of stay in Baltimore: Yrs. Mos. Days: 1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-Md
D. STREET ADDRESS (If rural, give location): 912 N Carrollton Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | N | Single | 8/15/49 | | | 10 / 43 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NBorn
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Gillis
14. MOTHER'S MAIDEN NAME: Rita Oliver Conway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) ND (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Ruth Gillis ADDRESS: 912 N Carrollton Ave

## 18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 12 hr.

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 15, 1949 *to* Aug 15, 1949, *that I last saw the deceased alive on* Aug 15, 1949, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard D. Amanda M.D.
23B. ADDRESS: 2309 Druid Hill Ave
23C. DATE SIGNED: 8-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): SEP 13 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

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-22-

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

760 Registered No. G78282

H NO. B.C. 49-18787

NAME OF DECEASED (Type or Print): Boy Miller

2. DATE OF DEATH: Sept. 8, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore, Inc.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 2903 Dunmorry Rd. #22

Length of stay in Baltimore: 11 hrs. (Yrs. Mos. Days)

SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: Sept. 8, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours 10, Min. 56

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Sinai Hospital, Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George S. Miller, Jr.
14. MOTHER'S MAIDEN NAME: Marie Agnes Bruce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: mother - Mrs. Marie Miller
ADDRESS

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — Tear of tentorium cerebelli

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hemorrhage into adrenal glands

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hydrocephaloid, left

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Sept, 19 49, *to* 8 Sept, 19 49, *that I last saw the deceased alive on* 8 Sept, 19 49, *and that death occurred at* 11 30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney Green M.D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 10 Sept 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SURGICAL
24D. LOCATION (City, town, or county) (State): SEP 13 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078283

H NO.

NAME OF DECEASED (Or Print): Mr. George Smith

2 DATE OF DEATH: 9-1-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 26-12
D. STREET ADDRESS (If rural, give location): No Home (BALTO. CITY HOSPITALS)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | April 14, 1869 | 80? | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (D)
14. MOTHER'S MAIDEN NAME: (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS* BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Septicemia | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23 19 49 *to* 9-1- 19 49 *that I last saw the deceased alive on* 9-1 19 49 *and that death occurred at* 10:10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Bogen M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 9-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL SEP 15 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

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84

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78284

H NO. 49 - 21990

| | |
|---|---|
| NAME OF DECEASED (or Print) | Baby Kelly |
| 2 DATE OF DEATH | Sept. 13, 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A STATE | Maryland |
| B COUNTY | |
| C CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 3-01 |
| D STREET ADDRESS (If rural, give location) | 266 Dallas Court |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Sinai Hospital |
| Length of stay in Baltimore | life (Yrs. Mos. Days) |
| SEX | male |
| 6. COLOR OR RACE | white |
| 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | |
| 8 DATE OF BIRTH | Sept. 6, 1949 |
| 9 AGE (In years last birthday) (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.) | 7 |
| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10a KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) | Baltimore, Maryland |
| 12 CITIZEN OF WHAT COUNTRY? | |
| FATHER'S NAME | Thomas Kelly |
| 14 MOTHER'S MAIDEN NAME | Joyce |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | |
| 16 SOCIAL SECURITY NO | |
| 17 INFORMANT ADDRESS | (Information taken from chart) |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prem atority | 7 days |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ✓ NO |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 9 - 6, 1949 *to* 9 - 13, 1949 *that I last saw the deceased alive on* 9 - 13, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| Judith R. Lawlan M. D. | Sinai Hospital Baltimore | 10-14-49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL SEP 16 1949 |
| 24D. LOCATION (City, town, or county) (State) | | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
| 12/1/49 | Huntington Williams, M.D. | Commissioner of Health |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

NAME OF DECEASED (Type or Print): Mary Louise Peters

2. DATE OF DEATH: Sept. 16, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 1015 Providence St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1015 Providence St.

Length of stay in Baltimore: Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widow | Nov. 17, 1877 | 71 72 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pikesville, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Talbot Smith
14. MOTHER'S MAIDEN NAME: Jennie Hill
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Virginia Jones ADDRESS 1015 Providence St

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — DUE TO

(B) — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: July 22 to Sept. 18, 1949

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10 *to* 9-18, 1949, *that I last saw the deceased alive on* 9-17, 1949, *and that death occurred at* 10:40 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: C. Campbell M. D.
23B. ADDRESS: 718 Dolphin St.
23C. DATE SIGNED: 9-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/21/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.
REGISTRAR'S SIGNATURE: Pending Williams, M.D.
25. FUNERAL DIRECTOR: J. Holland Funeral Home ADDRESS 1681 Druid Hill Ave

DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949

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286 BALTIMORE CITY HEALTH DEPARTMENT G78286
CERTIFICATE OF DEATH 002 Registered No.

H NO.

NAME OF DECEASED (or Print) Oehler Simpson

2. DATE OF DEATH Sept. 19, 1949

LACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

ULL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-01

ength of stay in Baltimore 12 Yrs Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 608 S. Charles St.

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | 8/15/1902 | 47 | | |

| USUAL OCCUPATION (Give kind of ork done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| orer | | Chester, S.C | |

FATHER'S NAME Furman Simpson

14. MOTHER'S MAIDEN NAME Bessie Williams

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Bessie Hall ADDRESS 14 W. York Street

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| William J. McClafferty M.D. | | Sept. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| emoval | 5/22/49 | Chester | South Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | J. L. Brown & Son 108 W Montgomery St |

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78287 BALTIMORE CITY HEALTH DEPARTMENT G78287

# CERTIFICATE OF DEATH

Registered No.

H NO.

| | | | |
|---|---|---|---|
| NAME OF DECEASED (or Print) | MARY ALICE HAYES | 2. DATE OF DEATH | September 19, 1949 |
| PLACE OF DEATH: | Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | University Hospital | B. COUNTY | |
| | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 22-02 |
| Length of stay in Baltimore | Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) | 610 Montgomery Street |
| 5. SEX | female | 6. COLOR OR RACE | Colored |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | | 8. DATE OF BIRTH | Sept-23-1896 |
| 9. AGE (In years last birthday) | 52 53 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
| 10. USUAL OCCUPATION (Give kind of one during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Danville Va | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Richard Hayes | 14. MOTHER'S MAIDEN NAME | Ella Nunley |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | James Robinson | ADDRESS | 610 W. Montgomery St |

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| | | |
|---|---|---|
| 23A. SIGNATURE Carl L Rogers M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 9-19-49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/23/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Ct — 24D. LOCATION (City, town, or county) (State) A.A.Co., Md. |
| DATE RECEIVED BY LOCAL REGISTRAR SEP 21 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR 1062 W — ADDRESS V. L. Brown Son - Montgomery St |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

H NO.

ME OF DECEASED (or Print) William E. Scott

2. DATE OF DEATH Sept. 18, 1949

ACE OF DEATH: ltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY

LL NAME OF ITAL OR TUTION (If not in hospital or institution, give street address or location) 210 W. Chase Street

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-03

ngth of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 210 W. Chase Street

| X | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| le | Colored | Widowed | Mar. 20, 1886 | 63 | | |

| USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| auling | Self | Maryland | U. S. A. |

ATHER'S NAME James Scott

14. MOTHER'S MAIDEN NAME Unknown

| AS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Viola Scott | 210 W. Chase St. |

## CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Vascular Disease | 6 months |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 10 1949 *to* Sept 18, 1949, *that I last saw the deceased alive on* Sept 18, 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | | 9-20-49 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-22-49 | Mt. Auburn Cem | Baltimore, Md. |

| TE RECEIVED BY CAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Entry for Williams, M.D. | Mrs. Frances A. Hemsley | 578 W. Biddle St. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1 5 G78289
Registered No.

H NO.

| | |
|---|---|
| NAME OF DECEASED (or Print) | ADDIE PEARL BAYLESS |
| 2. DATE OF DEATH | Sept. 20, 1949 |
| PLACE OF DEATH: | altimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) | 2311 Calverton Heights Ave. |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 16 15 |
| ength of stay in Baltimore Yrs. Mos. Days | |
| D. STREET ADDRESS (If rural, give location) | 2311 Calverton Heights Ave. |
| EX | emale |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | single |
| 8. DATE OF BIRTH | Mar. 18, 1884 |
| 9. AGE (In years last birthday) If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min. | 65 yrs. |
| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | seamstress |
| 10a. KIND OF BUSINESS OR INDUSTRY | uniform company |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| ATHER'S NAME | Walter Scott Bayless |
| 14. MOTHER'S MAIDEN NAME | Mary L. Dorsch |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | Mr. Walter L. Buchingham |
| ADDRESS | Hgts.Av 2311 Calverton |

**CAUSE OF DEATH**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cancer Ovary | 4years |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
| June 20 1949 | Metastatic Ovarian Cancer | YES ☐ NO ☒ |
| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* June 1 19 49 *to* Sept 20 19 49 *that I last saw the deceased alive on* Sept 20 19 49 *and that death occurred at* 2:30 *A. M., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
| Mendelis M. D. | 651 N Bentalou | 9/20/49 |
| A. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY |
| Burial | 9/23/49 | Western Cem. |
| 24d. LOCATION (City, town, or county) (State) | | |
| Balto., Md. | | |
| ATE RECEIVED BY CAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
| SEP 21 1949 | Carlyle Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

TH NO. Registered No.

NAME OF DECEASED (or Print): EMANUEL E. SMITH

2. DATE OF DEATH: Sept 20, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4012 Ridgecroft Rd.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. Md. 27-01
D. STREET ADDRESS (If rural, give location): 4012 RIDGECROFT Rd.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | MAR 19, 1868 | 81 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| FARMER | SELF | NEW FREEDOM - PA | U.S.A. |

13. FATHER'S NAME: HENRY SMITH

14. MOTHER'S MAIDEN NAME: LEAH HEINDEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: STEWART K SMITH. ADDRESS: 4012 Ridgecroft

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yr.

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B)

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 1, 1946 *to* Sept 20, 1949, *that I last saw the deceased alive on* Sept 19, 1949 *and that death occurred at* 2:49 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Harris M. D. | 6232 Belair Rd. | Sept. 20, 1949 |

| A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/23/49 | Beth-El Lutheran Cem | STILTZ PA. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | Medred J. Blight | 600 Harford Rd |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50 Registered No.

3291

H NO.

NAME OF DECEASED (or Print) Alena Saunders

2. DATE OF DEATH Sept 17th 49

PLACE OF DEATH Baltimore City, Maryland Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1119 Busco St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21 01

D. STREET ADDRESS (If rural, give location) 1119 Busco St

Length of stay in Baltimore 23 yrs. (Yrs. Mos. Days)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | M. | Sept. 26-1902 | 46 | | |

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY Gen.

11. BIRTHPLACE (State or foreign country) Detroit Michigan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Steve Sanders Sr

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sarah Sanders ADDRESS 1119 Busco St

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of the esophagus | |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 18 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept. 21-49

24C. NAME OF CEMETERY OR CREMATORY Bat Calvary Cem.

24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Elroy S. Wilson ADDRESS 1000 Beverly

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292 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G78292
CERTIFICATE OF DEATH

H NO.

AME OF DECEASED (or Print): ELLA B. DONNELLY

2. DATE OF DEATH: 9/19/49

LACE OF DEATH: altimore City, Maryland

LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): 724 E. Preston street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 724 E. Preston street

ength of stay in Baltimore: 70 yrs. (Yrs. Mos. Days)

EX: ale | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow | 8. DATE OF BIRTH: June 14, 1872 | 9. AGE (In years last birthday): 77 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

USUAL OCCUPATION (Give kind of on during most of working life, even if retired): At home | 10a. KIND OF BUSINESS OR INDUSTRY: -- | 11. BIRTHPLACE (State or foreign country): Ireland | 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

FATHER'S NAME: ominic McNally | 14. MOTHER'S MAIDEN NAME: Jane---

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): no | 16. SOCIAL SECURITY NO: none | 17. INFORMANT: Mrs. Genevieve Garrigan ADDRESS: 724 E. Preston street

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive failure due to coronary artery Disease of the Heart — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis — ?

DUE TO

(C) Parkinson's Disease — 18 yrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 Jan, 1947 *to* 19 Sept, 1949, *that I last saw the deceased alive on* 18 Sept, 1949, *and that death occurred at* 3:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Samuel Silverfels M. D. | 23B. ADDRESS: 714 E. Preston St | 23C. DATE SIGNED: 20 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9/22/49 | 24C. NAME OF CEMETERY OR CREMATORY: New Cathedral | 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 21 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Chas. J. Evans & Son Inc. | ADDRESS: 118 N. Mt. Royal Ave.

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G78293 CERTIFICATE CORRECTED 9-23-49 ✓ No. 1 G78293

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

TH NO. Registered No.

NAME OF DECEASED (If Print) John Stout Graves

2. DATE OF DEATH September 19, 1949

PLACE OF DEATH: Baltimore City, Maryland 327 St. Paul Place

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-52
D. STREET ADDRESS (If rural, give location) 2627 Georgetown Road.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Married | 4/10/1881 | 68 | | | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10a. KIND OF BUSINESS OR INDUSTRY Contractor
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Graves
14. MOTHER'S MAIDEN NAME Mary Owens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-07-2774
17. INFORMANT Mrs John S Graves ADDRESS 2627 Georgetown

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerotic C-V. disease | |
| DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Patient was DOA ~~brought~~ to hospital. | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Dept of Public Welfare
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 327 St. Paul Place
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 19 1949 about 12 m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Collapsed while waiting for interview

22. I hereby certify that I attended the deceased from 1:05 p.m. - 9-19, 1949, to 1:05 p.m. 9-19, 1949, that I last saw the deceased alive on ——, 19—, and that death occurred ~~at~~ 1:05 p.m., from the causes and on the date stated above.

23A. SIGNATURE Clifford T. Riddel, Jr M. D.
23B. ADDRESS
23C. DATE SIGNED 9/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 9/22/49
24C. NAME OF CEMETERY OR CREMATORY Jacob Stone Cem
24D. LOCATION (City, town, or county) (State) Beachwood Md Mary Co

DATE RECEIVED BY LOCAL REGISTRAR SEP 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Baker & Land ADDRESS 13 E Light St

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 3698

TH NO.

NAME OF DECEASED (Type or Print) Elmira Hall

2. DATE OF DEATH 9-20-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1135 N. Carrollton Ave

Length of stay in Baltimore 5 years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 16-01
D. STREET ADDRESS (If rural, give location) 1135 N. Carrollton Ave

| SEX | 6. COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widowed | 6-6-1899 | 50 | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | own home | Lancaster Co. Va | U. S. A. |

13. FATHER'S NAME David Jones

14. MOTHER'S MAIDEN NAME Nancy Layton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Cora Botchelora ADDRESS 812 Whatcoat St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension & Artero Sclerosis — Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-14 *,* 1949 *to* 9-20 *,* 1949 *that I last saw the deceased alive on* 9-19 *,* 1949 *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dave D. Saunders M. D. | 1029 N. Stricker St. | 9-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9 23 49 | Whitelone | Whitelone Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Huntington Williams, M.D. | Leo. A. Nelson | 1303 |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

46 G78295 Registered No.

TH NO. G78295

NAME OF DECEASED (Type or Print) WILLIAM KELLY SESSOMS

2. DATE OF DEATH Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

Length of stay in Baltimore 233 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Va.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Portsmouth
D. STREET ADDRESS (If rural, give location) 222 Henry St.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | 6/9/06 | 43 | | | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) NC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm. K. Sessoms
14. MOTHER'S MAIDEN NAME Cora Mc Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 248-12-4726
17. INFORMANT Records- US Marine Hospital, Balto, Md. (ADDRESS)

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of nasopharynx with metastases to cervical lymph nodes | Unknown |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 31, 1949 *to* Sept. 21, 1949, *that I last saw the deceased alive on* Sept. 21 1949, *and that death occurred at* 7:05 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE OF M. D. L. Ray Howard, Surgeon
23B. ADDRESS US Marine Hospital, Balto, Md.
23C. DATE SIGNED 9/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) removal
24B. DATE Sept. 21, 1949
24C. NAME OF CEMETERY OR CREMATORY Vonore
24C. LOCATION (City, town, or county) (State) Vonore, Tennessee

DATE RECEIVED BY LOCAL REGISTRAR SEP 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street (ADDRESS)

45F

G78296 ✓ G78296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4720

TH NO.

NAME OF DECEASED (Type or Print): Clarence H. Moran

2 DATE OF DEATH: Sept. 20, 1949

PLACE OF DEATH: Baltimore City, Maryland Cambridge Arms Apts.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cambridge Arms

Length of stay in Baltimore: life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): Cambridge Arms Apts. 12-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| ale | white | widowed | Aug. 26, 1876 | 73 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): tired real estate
10B. KIND OF BUSINESS OR INDUSTRY: B. & O. R. R.
11 BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13 FATHER'S NAME: Charles Moran
14 MOTHER'S MAIDEN NAME: Theodosia Ridgeway
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Doris M. Sloan
ADDRESS: Cambridge Arms Apts.

## CAUSE OF DEATH

18.

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

(B) Chr. Coronary disease Chr. arteriosclerotic condition — 2 years

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Sep, 19[illegible] *to* 9-[illegible], 19[illegible] *that I last saw the deceased alive on* 9-15, 19[illegible] *and that death occurred at* 2A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr Bernard Cohen M. D.
23B ADDRESS: Marlboro Apt
23C DATE SIGNED: 9-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Sept. 21, 49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D LOCATION (City, town, or county) (State): Frederick Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: John O. Mitchell & Sons
ADDRESS: 1900 Eutaw Place

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G78297 ✓ G78297

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

TH NO. Registered No.

NAME OF DECEASED (Type or Print): ROBERT P WINTEROBE

2. DATE OF DEATH: 9-19-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12-02
D. STREET ADDRESS (If rural, give location): HOMEWOOD APTS., BALTO 18

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | FEB 17, 1875 | 74 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): PHYSICIAN
10B. KIND OF BUSINESS OR INDUSTRY: OWN PRACTICE
11. BIRTHPLACE (State or foreign country): BALTIMORE COUNTY
12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME: ? WINTEROBE
14. MOTHER'S MAIDEN NAME: MARY LOUISE WATTS

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO:
17. INFORMANT: DR. ROBT. GARRETT
ADDRESS: ANNAPOLIS

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) CORONARY OCCLUSION | ? 9DAYS |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) ARTERIOSCLEROTIC HEART DISEASE | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 17, 1949 *to* Sept 19, 1949 *that I last saw the deceased alive on* 19—1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas F. Nelson M. D.
23B. ADDRESS: Union Mem. Hosp.
23C. DATE SIGNED: 9-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 22/49
24C. NAME OF CEMETERY OR CREMATORY: David Rodgers Burg
24D. LOCATION (City, town, or county) (State): Pikesville Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell Jr.
ADDRESS: 102 Eastern Ave

937

G78298

# CERTIFICATE CORRECTED 1-25-50

G78298

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

H NO.

| | |
|---|---|
| NAME OF DECEASED (or Print) | Emma Damme |
| 2. DATE OF DEATH | Sept. 19, 1949. |
| PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 5-01 |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Mercy Hospital |
| D. STREET ADDRESS (If rural, give location) | 1241 East Lexington St. |
| Length of stay in Baltimore: Yrs. / Mos. / Days | Life |

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | Single | March 10, 1880 (1876) | 69 73 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Damme | Anna Hasselhoff |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Lulu Damme | 7241 E. Lexington St. |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 11 days |
| DUE TO (B) | Arteriosclerosis - Generalized | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 6 1949, *to* Sept. 19, 1949, *that I last saw the deceased alive on* Sept. 19, 1949, *and that death occurred at* 11 25P *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| John A. Spittel, Jr. M. D. | Mercy Hospital | Sept. 19, 1949 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept | Mt Carmel | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 21 1949 | Tuntington Williams M.D. | Ulrich Funeral Home | |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 33 1

TH NO. | Registered No.

NAME OF DECEASED (Type or Print): HENRY JENKINS ARTHUR

2. DATE OF DEATH: Sept. 20, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 616 East 34th St.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-03
D. STREET ADDRESS (If rural, give location): 616 East 34th Street

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1876 | 73 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | | Baltimore, Md. | |

13. FATHER'S NAME: Thomas H. Arthur

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT / ADDRESS: Mrs. H.J.Arthur-616 E. 34th Street

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 15 days |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arterio Sclerosis. | 2 |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 15, 19__, *to* Sept 20, 1949, *that I last saw the deceased alive on* Sept 20th, 19 49, *and that death occurred at* 2:12 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jessup H. E. Cross M. D. | 18 W 25th St. | Sept. 26 19 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/23/49 | Churchville Pres. Cem. | Harford Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | WIEDEFELD AND SON | GREENMOUNT AVE. & 22nd ST. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

H NO. Registered No.

1. NAME OF DECEASED (First) Steve (Middle) (Last) PARKER

2. DATE OF DEATH 9-20-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 905 Shield Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | negro | Married | March 5 1900 | 49 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Laborer
10a. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co.
11. BIRTHPLACE (State or foreign country) York County Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Dew Parker
14. MOTHER'S MAIDEN NAME Amanda Cain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Mary Cook ADDRESS 610 N. Eden St

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 21 hrs |
| DUE TO (B) | Hypertension | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-19, 1949, *to* 9-20, 1949, *that I last saw the deceased alive on* 9-20, 1949, *and that death occurred at* 5:05 P m., *from the causes and on the date stated above.*

23a. SIGNATURE William J. Holloway M. D.
23b. ADDRESS University Hospital
23c. DATE SIGNED 9-20-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept 24/49
24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.
24d. LOCATION (City, town, or county) (State) G. C. County Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949
REGISTRAR'S SIGNATURE Thomas Worthington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Mrs. Robert G. Elliott & Daughter 1124 N. Carrollton Ave. 83a

G78301 BALTIMORE CITY HEALTH DEPARTMENT G78301
CERTIFICATE OF DEATH Registered No.

TH NO.

NAME OF DECEASED (Type or Print): John McGinnis John Wm. MacInnes — 2. DATE OF DEATH: Sept. 20, 19[illegible]

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: 2 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville
D. STREET ADDRESS (If rural, give location): 803 Reisterstown

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Jan 20 1883 | 66 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watch Repr.
10a. KIND OF BUSINESS OR INDUSTRY: Jewelry Factory
11. BIRTHPLACE (State or foreign country): Boston, Mass.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Neil MacInnes
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 220-09-[illegible]
17. INFORMANT: Pikesville, Md. Mrs. Beatrice MacInnes

## CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
ANTECEDENT CAUSES
(B) Coronary thrombosis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Autopsy

22. *I certify that I took charge of the remains described above, held an* Inquest & Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Cemetery
24B. DATE: Sept 23-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Cemetery
24D. LOCATION (City, town, or county) (State): Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Frank H. Worrall, Pikesville, Md. — ADDRESS

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Dr. Lubin 320 Patapsco Ave - Cv 0456

G78502

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78502 Registered No.

G78502 NO.

NAME OF DECEASED (or Print): Margaret M. Nislein

2. DATE OF DEATH: 9/14/49 6 P.M.

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 25-04
D. STREET ADDRESS (If rural, give location): 423 Freeman St.

NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 423 Freeman St

Length of stay in Baltimore: Yrs. Mos. Days

SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: about 1874
9. AGE (Last birthday): about 75
If under 1 Year: Months Days
If under 24 Hours: Hours Min.

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: (Unknown) Schaefer
14. MOTHER'S MAIDEN NAME: Susanna (Unknown)

WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph Nislein ADDRESS: 422 Freeman St

## 18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arterio-Sclerotic Cardio Vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Aug 1, 1949, *to* Sept 17, 1949, *that I last saw the deceased alive on* Sept. 17, 19 49 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul Lubin M.D. M. D.
23B. ADDRESS: 320 Patapsco Ave.
23C. DATE SIGNED: 9/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/22/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

RECEIVED BY REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. N-861

TH NO.

NAME OF DECEASED (Type or Print): ALBERT GARRETT

2. DATE OF DEATH: September 18, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 16-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1129 Gilmor Street

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 2-13-1911 | 38 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10a. KIND OF BUSINESS OR INDUSTRY: Boston Metal Scrap Metals
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William Garrett
14. MOTHER'S MAIDEN NAME: Bertha Gurry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-05-7468
17. INFORMANT: Gladys Gordon ADDRESS: 1003 Brantly Ave.

## CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shot wound of chest — INTERVAL BETWEEN ONSET AND DEATH: dy

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1304 Fremont Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 18, 1949 9 P. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Emil L Beyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 9-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-23-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State): A. A. County Md.
DATE RECEIVED BY LOCAL REGISTRAR: SEP 21 1949
REGISTRAR'S SIGNATURE: Cunningham Williams, M.D.
25. FUNERAL DIRECTOR: William A. Jackson ADDRESS: 916 Penna Ave.

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304

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

171 Registered No. G78304

H NO.

NAME OF DECEASED (or Print): KITTY GOLDMAN

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.

Length of stay in Baltimore: 18 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NY
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New York
D. STREET ADDRESS (If rural, give location): 18 St. Marks Place

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 7/13/06 | 43 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Conn. | USA |

13. FATHER'S NAME: Eugene Paquett

14. MOTHER'S MAIDEN NAME: Ursule Carribeau

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | ? | Records- US Marine Hospital, Balto, Md. |

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Cervix
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Sept. 3, 1949 *to* Sept. 21, 1949 *that I last saw the deceased alive on* Sept. 21, 1949, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| William Gorman M. D. | US Marine Hospital, Balto, Md. | 9/21/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-24-49 | New Britain Cem Co | New Britain Ct. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5805 Harford Rd |

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305 G78305

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4500

TH NO.

NAME OF DECEASED (Type or Print) William M. Manning

2. DATE OF DEATH Sept. 1, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1030 Hanover St.

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1030 Hanover St. 23-01

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | U | U | 54 | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| N | K | N K | |

| FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | N O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| N | N | N | |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema

DUE TO

(B) Arterio sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Royster M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED Sept. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, Town or County) (State)

UNIVERSITY MEDICAL SCHOOL SEP 16 1949

DATE RECEIVED BY LOCAL REGISTRAR SEP 22 1949

REGISTRAR'S SIGNATURE Mary Fox Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

UNIVERSITY MEDICAL SCHOOL SEP 16 1949

Commissioner of Health

97

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 Registered No.

H NO.

NAME OF DECEASED (Type or Print): VANDERBILT BANKS

2. DATE OF DEATH: 9-3-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND PENITENTIARY HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: VIRGINIA
B. COUNTY: GLOUCESTER
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL
D. STREET ADDRESS (If rural, give location):

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | Colored | SINGLE | 9/10/1889 | 59 | 11 | 24 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| BARBER | | Virginia | U.S. |

FATHER'S NAME: PHILIP SMITH

14. MOTHER'S MAIDEN NAME: LAURA CORBIN

| WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| UNKNOWN | | | ALEXANDER BROWN | 1102 FEDERAL ST. BALTO. MD. |

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) AZOTEMIA — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) CHRONIC NEPHRITIS

DUE TO

(C) ARTERIOLAR NEPHROSCLEROSIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: 1. BRONCHOPNEUMONIA 2. DIABETES MELLITUS

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-22 1949, *to* 9-[illegible] 1949, *that I last saw the deceased alive on* 9-2 1949, *and that death occurred at* 3-32 *m., from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry W. Dölles M. D. | UNIVERSITY MEDICAL SCHOOL SEP 16 1949 | 9-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL SEP 16 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420.1 G78307 Registered No.

H NO.

| | |
|---|---|
| NAME OF DECEASED (or Print) HARRY SAMUELS | 2. DATE OF DEATH 9-21-49 |
| PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 7-03 |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2314 Jefferson St | C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township) |
| Length of stay in Baltimore 40 Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 2314 Jefferson St |
| 5. SEX Male | 6. COLOR OR RACE White |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH |
| 9. AGE (In years last birthday) 75 | If Under 1 Year: Months Days; If Under 24 Hours: Hours Min. |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dresser | 10b. KIND OF BUSINESS OR INDUSTRY Clothing |
| 11. BIRTHPLACE (State or foreign country) Russia | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Isaac | 14. MOTHER'S MAIDEN NAME Minnie |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
| 17. INFORMANT Minnie Samuels | ADDRESS 2314 Jefferson |

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Phlebitis, Cardiac Hypertrophy

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

no

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from June 48, to Sept 20, 19 49, that I last saw the deceased alive on Sept 20, 19 49, and that death occurred at 3:30 p.m. from the causes and on the date stated above.

| | | |
|---|---|---|
| 23A. SIGNATURE M. Rudash, M. D. | 23B. ADDRESS 2715 Druid Park Drive | 23C. DATE SIGNED 9/21/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-22-49 | 24C. NAME OF CEMETERY OR CREMATORY Rosedale |
| 24D. LOCATION (City, town, or county) (State) Balto Md | | |
| DATE RECEIVED BY LOCAL REGISTRAR SEP 22 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Jack Levin Inc. |
| ADDRESS 2100 Eutaw Pl | | |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

AME OF DECEASED (or Print): Mrs. Mary Knight

2. DATE OF DEATH: September 21, 1949

LACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-62
D. STREET ADDRESS (If rural, give location): 400 Whitridge Avenue

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

ength of stay in Baltimore — Yrs. Mos. Days

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| | White | Married | Mar. 7, 1896 | 53 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwfe.
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Gunning
14. MOTHER'S MAIDEN NAME: Catherine Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Mamie Schlueposer — ADDRESS: 400 Whitridge Ave

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute pancreatitis — DUE TO
ANTECEDENT CAUSES
(B) — DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic cholecystitis & cholelithiasis

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19A. DATE OF OPERATION: Sept. 20, 1949
19B. MAJOR FINDINGS OF OPERATION: Fat necrosis - pancreas - peripancreatic
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/19/ , 1949, to 9/21/ , 1949 that I last saw the deceased alive on 9/21/ , 1949, and that death occurred at 9:35 A.M., from the causes and on the date stated above.

23A. SIGNATURE: A. Andrew Alice, M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 9/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/24/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md
25. FUNERAL DIRECTOR: Edgar W. Conklin — ADDRESS: 924 E. Eager St.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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# CERTIFICATE CORRECTED

78309 — BALTIMORE CITY HEALTH DEPARTMENT — G78309

## CERTIFICATE OF DEATH

Registered No.

H NO.

NAME OF DECEASED (or Print): GEORGE M. ROBINSON

2. DATE OF DEATH: 9/21/49

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11

Length of stay in Baltimore: Yrs. / Mos. / Days

D STREET ADDRESS (If rural, give location): 603 South East Lane #24

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | WIDOWED | 9/23/1877 | 72 | 11 | 28 | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 216-03-5440

17. INFORMANT: Mrs. Mitchell — ADDRESS: 3908 Glenmore Ave.

### 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C) Decubitus, Bedsores

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9/15/49 *to* 9/21, 19 49, *that I last saw the deceased alive on* 9/21, 19 49, *and that death occurred at* 2:25 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Blanchard

23B. ADDRESS: Maryland General

23C. DATE SIGNED: 9/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 9/23/49

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7101 Belair Rd.

VS 150

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8310

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78310

TH NO.

NAME OF DECEASED (Type or Print): Abraham I. Caplan

2. DATE OF DEATH: Sept. 21/49

PLACE OF DEATH: Baltimore City, Maryland 4004 Maine Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: 58 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 4004 Maine Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 17 1873 | 75 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Whol. Gen. Merchandise Butler Bros.
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Caplan
14. MOTHER'S MAIDEN NAME: Ruth Ziskind

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah G. Caplan ADDRESS: 4004 Maine Ave.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis Cardiac Failure | 1 hr. |
| DUE TO (B) | Chr Bleeding Gastric ulcer | 1 yr. |
| DUE TO (C) | — | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1935 *to* Sep. 21 1949 *that I last saw the deceased alive on* Sep 21, 1949 *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr Bernard Cohen M. D.
23B. ADDRESS: Maryland apt
23C. DATE SIGNED: 9-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 22, 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

117a

8311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

5 43 G78311 Registered No.

H NO.

NAME OF DECEASED (or Print) William Roane

2. DATE OF DEATH 9-20-49

PLACE OF DEATH: Baltimore City, Maryland 1415 Mosher St

ALL NAME OF HOSPITAL OR STITUTION (If not in hospital or institution, give street address or location) none

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1415 Mosher Balto md
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto md 16-02
D. STREET ADDRESS (If rural, give location) 1415 Mosher St

Length of stay in Baltimore: Yrs. 52 yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | Negro | married | Jan 1 1880 | 69 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer & Chauffer
10B. KIND OF BUSINESS OR INDUSTRY: ODD JOBS
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME: George Roane
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Sarah Roane ADDRESS: 1415 Mosher

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chron Gastritis
DUE TO
(B) General Debility
DUE TO
(C) Cardiac failure, Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16 1949 *to* Sept 20, 1949 *that I last saw the deceased alive on* 9-20-1949, *and that death occurred at* 3:15 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: Wm K. Boykin M.D.
23B. ADDRESS: 1133 N. Monroe
23C. DATE SIGNED: 9-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/23/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Arbutus Md.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Metropolitan Funeral Home Inc
93E 927 N. Mount St.

VS 150

78312 BALTIMORE CITY HEALTH DEPARTMENT 57 1.0 G78312

H NO. B.C.H. 25501 **CERTIFICATE OF DEATH** Registered No.

AME OF DECEASED (or Print): Harry Fletcher

2. DATE OF DEATH: 20 Sept '49

LACE OF DEATH: altimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): University Hosp. Balto Md.

ength of stay in Baltimore: Yrs. 11 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1223 N. Stricker St

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | Oct 48 | | 11 | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

FATHER'S NAME: Harvey Fletcher
14. MOTHER'S MAIDEN NAME: Alice?

WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Harvey Fletcher ADDRESS: 1322 N. Stricker

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Diarrhea & Dehydration & Acidosis | 10 d. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Bronchopneumonia | 2d. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 14, 1949, *to* Sept 20, 1949, *that I last saw the deceased alive on* Sept 20, 1949, *and that death occurred at* 4 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E A Broaddus M. D.
23B. ADDRESS: Univ. Hosp. Balto Md.
23C. DATE SIGNED: 9-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/22/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Maryland

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halsted
ADDRESS: 918 Druid Hill Ave, 1192

VS 150

8313 ✓ G78313

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

443 Registered No.

H NO.

NAME OF DECEASED (or Print): Katherine Morrow

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland — Balto Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4506 Sorrento ave

Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 11-04
D. STREET ADDRESS (If rural, give location): 1309 Linden ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | single | May. 30 1876 | 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto md
12. CITIZEN OF WHAT COUNTRY? usa

FATHER'S NAME: William G. Morrow
14. MOTHER'S MAIDEN NAME: Mary a. Lavery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Morrow — ADDRESS: 1436 E Fayette St

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac failure
DUE TO
(B) Hypertension Cardio
DUE TO
(C) Vascular disease

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

INTERVAL BETWEEN ONSET AND DEATH: ?

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 10, 1949 *to* Sept 21, 1949 *that I last saw the deceased alive on* Sept 21 19 49 *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jer McKiaffer M. D.
23B. ADDRESS: 2470 Park Blvd
23C. DATE SIGNED: Sept 22 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/23/49
24C. NAME OF CEMETERY OR CREMATORY: New Cath
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Buck — ADDRESS: 5305 Reisterstown Rd

VS 150

937

978314

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 978314

TH NO.

NAME OF DECEASED (Type or Print) Rose Provenza

2. DATE OF DEATH 9/21/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-01
D. STREET ADDRESS (If rural, give location) 1300 Andrea St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Feb. 25 1884 | 65 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Joseph Tambura
14. MOTHER'S MAIDEN NAME Rosa Brocato
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Frank Provenza ADDRESS Carlel Beach A.A. Co.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MYOCARDIAL FAILURE
DUE TO
(B) HYPERTENSIVE HEART DISEASE
DUE TO
(C) ARTERIOSCLEROTIC HEART DISEASE

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/21, 1949, *to* 9/21, 1949, *that I last saw the deceased alive on* 9/21, 1949, *and that death occurred at* 12:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Samuel P. Scalia M. D.
23B. ADDRESS
23C. DATE SIGNED 9/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 9/24/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral
24D. LOCATION (City, town, or county) (State) Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR SEP 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John F. Denny, Inc. ADDRESS 715 Light St.

VS 150

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315

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

450.0 G78:315

Registered No.

TH NO.

| | | | |
|---|---|---|---|
| NAME OF DECEASED (Type or Print) | JOHN | WILLIAMS | 2. DATE OF DEATH: September 19, 1949 |

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 823 Pierce Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widowed | Feb. 15, 1881 | 68 69 | | |

| 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Va | U. S. A. |

13. FATHER'S NAME: John Williams

14. MOTHER'S MAIDEN NAME: Eliza Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Irene Montray | 823 Pierce St |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteric-sclerosis | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp& Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Carl L. Rogers M.D. | | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/23/1949 | Mt. Calvary | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

97

8316

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078316

TH NO.

NAME OF DECEASED (Type or Print): LILIAN D. Williamson

2. DATE OF DEATH: 9/21/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Relay
D. STREET ADDRESS (If rural, give location): Gun Road

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | April 4, 1869 | 80 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland (Balto.)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Diffenderfer
14. MOTHER'S MAIDEN NAME: Anna E. Hoke

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Calvert Williamson ADDRESS: Gun Rd., Relay

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute gastrointestinal hemorrhage | 1 day? |
| DUE TO | (B) Ulcerative enteritis | ? |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Generalized arteriosclerosis | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/20 19 49 *to* 9/22 19 49 *that I last saw the deceased alive on* 9/21 19 49 *and that death occurred at* 1 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Hubert H. Jenkins M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 9/23/49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount Crem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

120B

8317

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78317

H NO.

AME OF DECEASED or Print): Herman Lotterer

2. DATE OF DEATH: 9/22/49

ACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 27 (Lansdowne)

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital
D. STREET ADDRESS (If rural, give location): 246 1st Avenue

ength of stay in Baltimore: Yrs. 7 Mos. Days

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | Jan. 11, 1864 | 85 | | |

| USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Butcher (Ret.) | SELF | Germany | ? |

FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes or unknown, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | | Leo J. Lotterer | Halethorpe, Md. |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Congestive heart failure | |
| ANTECEDENT CAUSES | DUE TO (B) Arteriosclerotic Cardiovascular | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO Disease | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 20, 1949 to Sept 22, 1949, *that I last saw the deceased alive on* Sept 21, 1949, *and that death occurred at* 12:50 p.m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Peter J. Levitas M. D. | St Agnes Hospital | 9-22-49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/26/49 | Cathedral | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | B. C. Forle | 121 E. West St. |

VS 150

931

8318 G78318

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 Registered No.

H NO.

NAME OF DECEASED (Type or Print): ANNA PULASKI

2. DATE OF DEATH: SEPT. 20-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 804 W. Lombard St.

Length of stay in Baltimore: 39 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 18-03
D. STREET ADDRESS (If rural, give location): 804 W. LOMBARD ST.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | ? -1895 | 54 | - | - | - | - |

| 10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | | LITHUANIA | U.S.A. |

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | None | JOSEPH PULASKI | 804 W LOMBARD ST |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL HEMORRHAGE
DUE TO ARTERIOSCLEROSIS
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4½ MOS

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. I hereby certify that I attended the deceased from 11 May, 1949 to 20 Sept, 1949, that I last saw the deceased alive on 20 Sept, 1949, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

| 23A. SIGNATURE, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward F. Mullen | 682 WASHINGTON BLVD | 21 SEPT 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Sept 25, 1949 | Holy Redeemer | Edgar Rd Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Charles W. Tschaunkaa | 703 McHenry St |

VS 150

8 3a

8319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

570.3

Registered No. 078319

TH NO.

NAME OF DECEASED (Type or Print): CHARLES G. CHEVALIER

2 DATE OF DEATH: 9-20-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 509 Lowry Lane

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Married | June 7, 1873 | 076 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Vermont
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Napoleon Chevalier
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Sylvia Chevalier ADDRESS: 509 Lowry Lane

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | INTESTINAL OBSTRUCTION | 5 days ± |
| DUE TO (B) | VOLVULUS | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION: 9-20-49
19b. MAJOR FINDINGS OF OPERATION: VOLVULUS
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-20 , 19 49 *to* 9-20 , 19 49 *that I last saw the deceased alive on* 9-20 , 19 49 *and that death occurred at* 12:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Hubert K. Jones M. D.
23b. ADDRESS: University Hosp.
23c. DATE SIGNED: 9-22-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 9 22 49
24c. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Crematory
24d. LOCATION (City, town, or county) (State): 3801 Frdk. Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Turlington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Wirtle
ADDRESS: 4101 Edmondson Ave.

VS 150

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8320 G78320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

H NO.

1. NAME OF DECEASED (Type or Print) Frederick P. Vogelgesang

2. DATE OF DEATH 9/21/49

PLACE OF DEATH: Baltimore City, Maryland

3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-07

D. STREET ADDRESS (If rural, give location) 3201 Westmont Ave

NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Agnes Hospital

Length of stay in Baltimore 45 yrs (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 5/30/1897 | 52 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist | Dry Dock Co. | Lancaster Pa. | USA |

13. FATHER'S NAME Frederick P. Vogelgesang Jr.

14. MOTHER'S MAIDEN NAME Sarah Lowe

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| World War I | | Edna S. Vogelgesang | 3201 Ave Westmont |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Coronary occlusion | Immediate |
| DUE TO (B) | Hypertensive Cardio Vas. disease. | Years. |
| DUE TO (C) | Obesity | Years. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
For Dr. J.R. Davis per
R S Fisher M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. , 1946 *to* Sept 20 , 1949 *that I last saw the deceased alive on* Sept 20 , 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles Comaroffo M. D.

23B. ADDRESS 920 W. Lombard St

23C. DATE SIGNED Sept. 20 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/26/49

24C. NAME OF CEMETERY OR CREMATORY Balto Natl Cem.

24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR SEP. 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J. Cowan & Son

ADDRESS 907 Hollins St.

VS 150

B-128746

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

57-3 G78321 Registered No.

78321 BC-49-0946 H NO.

NAME OF DECEASED (Type or Print): Baby Boy Desper

2. DATE OF DEATH: 9-14-1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 8 Irvin Place zone 31

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | May 4-1949 | | 4 | 10 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wilson Edward Desper
14. MOTHER'S MAIDEN NAME: Beatrice Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records: ADDRESS 4940 Eastern Ave.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Malformations of the kidneys.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 8-30-1949 — 9-2-1949
19B. MAJOR FINDINGS OF OPERATION: Rt. Nephrectomy — Exploratory
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-4 , 1949 *to* 9-14 , 1949, *that I last saw the deceased alive on* 9-14 , 1949, *and that death occurred at* 8.10A *m., from the causes and on the date stated above.*

23A. SIGNATURE: C.S. Cooper M.D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: Sept.17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: Sept.17,49
24C. NAME OF CEMETERY OR CREMATORY: B.C.H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

157H

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78322

49-18452

NAME OF DECEASED (Type or Print): Baby Boy Storm

2. DATE OF DEATH: August 31, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

Length of stay in Baltimore: 0 Yrs. 0 Mos. 9 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-48
D. STREET ADDRESS (If rural, give location): 5611 Lothian Road

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | S | August 30, 1949 | | | | 5 | 8 |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harline Storm
14. MOTHER'S MAIDEN NAME: Arleen Kluse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: The Johns Hopkins Hospital
ADDRESS: 9-1-49

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Spina Bifida | |
| DUE TO (B) | Meningocele | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 30, 19 49 *to* August 31, 19 49 *that I last saw the deceased alive on* August 31, 19 49, *and that death occurred at* 3:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: M. Andrews M. D.
23b. ADDRESS:
23c. DATE SIGNED: 9-1-49

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE:
24c. NAME OF CEMETERY OR CREMATORY: Loudon Park
24d. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

157B

323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 3 ✓ Registered No. 678323

H NO.

1. NAME OF DECEASED (or Print): MAE CARLIN REA

2. DATE OF DEATH: SEPT. 19, 1949

PLACE OF DEATH: Baltimore City, Maryland

USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 12-03

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2702 GUILFORD AVE.

D. STREET ADDRESS (If rural, give location): 2702 GUILFORD AVE.

Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | WIDOWED | 5-?-1877 | 72 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): BALTO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: FRANK CARLIN

14. MOTHER'S MAIDEN NAME: MARY DEANE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: FAMILY RECORDS ADDRESS:

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral thrombosis | 2 min. |
| DUE TO (B) | arteriosclerosis | 2 years |
| DUE TO (C) | Hypertension. | 2 years. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-13- 19 49, *to* 9/19/ 19 49, *that I last saw the deceased alive on* 9/19 19 49, *and that death occurred at* 6:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Egbert L. Mortimer Jr. M. D.

23b. ADDRESS: 2706 St Paul St

23c. DATE SIGNED: 9/22/49

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 9-23-1949

24c. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL

24d. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO. ADDRESS: YORK RD. 4905

VS 150

836

8324

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-0.1

Registered No. 078324

H NO.

NAME OF DECEASED (or Print): Joseph Hardy

2. DATE OF DEATH: Sept. 20. 1949

PLACE OF DEATH: altimore City, Maryland Baltimore City Ct.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I4oI Mullikin Court 5-01

LL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location): I40I Mullikin Court

Length of stay in Baltimore: I8 Yrs. (Yrs. Mos. Days)

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| le | Col. | Married | Sept.28.I900 | 48 | | |

10. USUAL OCCUPATION (Give kind of ... during most of working life, even if retired): Grocer
10a. KIND OF BUSINESS OR INDUSTRY: For Self
11. BIRTHPLACE (State or foreign country): Greensvill N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME: orah Hardy
14. MOTHER'S MAIDEN NAME: Unkown

WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Hardy ADDRESS: I40I Mullikin Court

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis
DUE TO
(B) Arteriosclerosis -
DUE TO
(C) Chr. Cardiac Failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/1, 19 48, *to* Sept 20, 19 49, *that I last saw the deceased alive on* Sept. 19, 19 49, *and that death occurred at* 5A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas H. Carter, Jr. M. D.
23B. ADDRESS: 1715 Pennsylvania Ave.
23C. DATE SIGNED: 9/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept.23.49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park Cem.
24D. LOCATION (City, town, or county) (State): Arbutus Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Courtesy of Williams, MD
25 FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: I000 Brantly Ave.

VS 150

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8325

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 678325

TH NO.

NAME OF DECEASED (or Print): Clementine Dehne

2. DATE OF DEATH: 9/21/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore – 23 21-06
D. STREET ADDRESS (If rural, give location): 504 Brunswick St

SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10/09/1870
9. AGE (In years last birthday): 78
If Under 1 Year: Months 11 Days 9
If Under 24 Hours: Hours Min.

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME: ? Deceased
14. MOTHER'S MAIDEN NAME: ? Deceased

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: August Dehne ADDRESS: 504 Brunswick St.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO Disease
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Entrante cholecystitis & lithiasis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/14 19 49 *to* 9/21 19 49 *that I last saw the deceased alive on* 9/21 19 49 *and that death occurred at* 2:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert J. Kerickas M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 9/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 24-Sept-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore – Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: F. B. Wippel & Son
ADDRESS: 800 Eastern Ave.

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78326 G78326

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. Dr. Moseley

H NO.

NAME OF DECEASED (or Print): Frank C. Hoodless

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

WHOLE NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2239 Pennsylvania Ave.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-13
D. STREET ADDRESS (If rural, give location): 2239 Pennsylvania Ave.

SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: 6/8/1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10a. KIND OF BUSINESS OR INDUSTRY: PRIVATE FAMILY
11. BIRTHPLACE (State or foreign country): Union, S. C.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Codozia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or Unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Edith Gardner ADDRESS 2239 Penna. Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Congestive Heart Failure. | 3 days. |
| DUE TO | | |
| (B) | Hypertensive Cardiovascular Disease | |
| DUE TO | | |
| (C) | | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1949, *to* Sept 21, 1949, *that I last saw the deceased alive on* Sept 19, 1949, *and that death occurred at* 3. 40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert L Moseley M. D.
23B. ADDRESS: 1325 W. Lanvale St
23C. DATE SIGNED: 9/22/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/23/1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Entered for Baltimore, Md.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1601 Druid Hill Ave.
939

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8327

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78327

NO.

ME OF DECEASED (or Print) William J. O'Neill

2. DATE OF DEATH Sept. 20, 1949

ACE OF DEATH: Baltimore City, Maryland 1400 N. Lexington St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 19-02

L NAME OF ITAL OR TUTION (If not in hospital or institution, give street address or location) Aged Women's and Aged Mens Home

ngth of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | W. | W. | June 31 1868 | 81 | 3 | 17 | | |

USUAL OCCUPATION (Give kind of working most of working life, even if retired) Packer
10a. KIND OF BUSINESS OR INDUSTRY Butler Bros.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

ATHER'S NAME Charles O'Neill
14. MOTHER'S MAIDEN NAME Mary Burns

AS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 24-07-6901
17. INFORMANT L. W. Read ADDRESS 1400 N. Lexington St.

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Thrombosis | 1 hr |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Coronary Sclerosis | |
| | DUE TO | |
| | (C) Diabetes Mellitus | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September, 1948, to September 19, 1949, *that I last saw the deceased alive on* September 19 1949, *and that death occurred at* 3 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Newland Edward Day M. D. | 23B. ADDRESS 4-E-33rd St - 18 | 23C. DATE SIGNED Sept 22 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9/23/49 | 24C. NAME OF CEMETERY OR CREMATORY Western | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 22 1949 | REGISTRAR'S SIGNATURE Huntington Nolhamus, Mgr | 25. FUNERAL DIRECTOR Wm. Cook, Inc. ADDRESS 1217 St. Paul St

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8328

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

773 0

078328 Registered No.

H NO. BC-49-19353

AME OF DECEASED (or Print) William H. Ross

2. DATE OF DEATH 9-13-49

LACE OF DEATH: altimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) University Hospital

ength of stay in Baltimore 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md 16-02
D. STREET ADDRESS (If rural, give location) 1021 Whetcoat

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Black | infant | 9-12-49 | | 12 | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Md | |

FATHER'S NAME: William Ross

14. MOTHER'S MAIDEN NAME: Catherine Braxton

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Scleroma | 36 hrs |
| | DUE TO (B) | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-12, 1949 *to* 9-13, 1949, *that I last saw the deceased alive on* 9-13, 1949, *and that death occurred at* 2.30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. A. Broaddus M. D. | University Hospital | 9-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | SEP 22 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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8329

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78329

H NO.

1. NAME OF DECEASED (or Print): Baby Girl FRANKLIN

2. DATE OF DEATH: 9-14-49

ACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 3121 Barclay St.

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location): Maryland University Hospital.

ength of stay in Baltimore: Yrs. 1 Mos. Days

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years, last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | | 9-13-49 | | 1 | |

USUAL OCCUPATION (Give kind of ne during most of working life, even if retired): Laborer

10a. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.

ATHER'S NAME: Ralph Franklin

14. MOTHER'S MAIDEN NAME: Sarah HARMON

WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mother ADDRESS: 3121 Barclay Balt. Md.

## CAUSE OF DEATH

8. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) .m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13, 1949, to 9-14, 1949, *that I last saw the deceased alive on* 9-14, 1949 *and that death occurred at* 3A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] M. D.

23b. ADDRESS

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL SEP 22 1949

24d. LOCATION (City, town, or county) (State)

ATE RECEIVED BY OCAL REGISTRAR: SEP 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS

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3330 ✓ 60.0 G78330

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

H NO. B.C. 49-9479

NAME OF DECEASED (or Print): Baby Boy Fletcher

2. DATE OF DEATH: 9-18-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

Length of stay in Baltimore: 42¼ hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 13-05
D. STREET ADDRESS (If rural, give location)

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | W | S | 9-16-49 | | | 1 | 18 | 15 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Frances Fletcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 42¼ hrs +

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) None

DUE TO

(C) None

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 9-16, 1949 *to* 9-18, 1949, *that I last saw the deceased alive on* 9-18, 1949, *and that death occurred at* 6:10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. C. Fridge, M. D.
23B. ADDRESS: W. Balt. Hosp.
23C. DATE SIGNED: 9-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: University Medical School
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS
SEP 22 1949
Commissioner of Health

VS 150

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78331 G78331

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 v. 1 Registered No.

H NO.

NAME OF DECEASED (or Print): Antonia Kosar

2. DATE OF DEATH: May 28, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1522 Cherry Street

Length of stay in Baltimore: Yrs. - Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1522 Cherry St. 25-05

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 10, 1872 | 76 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Czechoslovakia | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Soustek | unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | | - | Mrs. Joseph Kosar | 1522 Cherry St. |

## 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis | 2 hrs. |
| DUE TO | | |
| (B) | Arteriosclerotic Cardio-vascular disease | |
| DUE TO | | |
| (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Coronary thrombosis-1 year ago

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1-1-, 1949, *to* 5-27-, 1949 *that I last saw the deceased alive on* 5-27-1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Sidney P. Gablert M. D. | 4700 Pennsylvania Ave. | 9/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 5-31-49 | Holy Cross Cemetery | Ritchie Highway |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. | 2601-3-5 E. Madison St. |

VS 150

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78332 ✓ Yr. 1 078332

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

H NO. Registered No.

NAME OF DECEASED (or Print): Edward Serp, Sr.

2. DATE OF DEATH: May 17, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4910 Pennington Ave.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-05
D. STREET ADDRESS (If rural, give location): 4910 Pennington Ave.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 27, 1875 | 74 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired JANITOR | SCHOOL | Czechoslovakia | U.S. |

13. FATHER'S NAME: Joseph Serp

14. MOTHER'S MAIDEN NAME: Barbara Svanberk

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes or unknown, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT — ADDRESS |
|---|---|---|
| no | none | Mrs. Anna Serp - 4910 Pennington Ave. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Thrombosis | few min. |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerotic cardio-vascular disease | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Congestive heart failure-chronic | 3 mos. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5-1- , 1949, *to* 5-17- , 1949, *that I last saw the deceased alive on* 5-10- , 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Sidney P. Gehlert M. D. | 4700 Pennington Ave. | 9/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 5-21-49 | Holy Cross Cemetery | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| 5-20-49 | Thurlington Williams, M.D. | Schmunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 150

93

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 30 Registered No. 078:533

:533

TH NO.

NAME OF DECEASED (Type or Print) Charles Rickett

2 DATE OF DEATH 8-27-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02
D. STREET ADDRESS (If rural, give location) 628 - Smithson

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro | U | | 65 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. KIND OF BUSINESS OR INDUSTRY K

11. BIRTHPLACE (State or foreign country) K
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME N O
14. MOTHER'S MAIDEN NAME U

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO N
17. INFORMANT N ADDRESS

## CAUSE OF DEATH

18.

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(B)

**ANTECEDENT CAUSES**
**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION LAST.**
DUE TO
(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26-, 1949 *to* 8-27, 1949, *that I last saw the deceased alive on* 8-27, 1949, *and that death occurred at* 1 7 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS [illegible]
23C. DATE SIGNED 8-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY University Medical School SEP 2 2 1949
24D. LOCATION (City, town, or county) (State) ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 22 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Commissioner of Health

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 51 G78:334

Registered No.

H NO.

NAME OF DECEASED (or Print) **Frances Palmer**

2. DATE OF DEATH **9-12-49**

PLACE OF DEATH: **altimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md**
B COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Balto. City Hospitals**

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Balto** 5-01

Length of stay in Baltimore: Yrs. **?** Mos. Days

D. STREET ADDRESS (If rural, give location) **146 N. Exeter St.**

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **male** | **Negro** | **?** | **?** | **30?** | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | **N.C.** | |

| FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| **?** | **?** |

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | **RECORDS*BALTO. CITY HOSPITALS** | **4940 EASTERN AVE** |

## CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Central Nervous System Disease**
DUE TO **Non Inflammatory Etiology Undetermined**

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B)
DUE TO

(C) **Anemia Mental Retardation -Spastic Paraplegia**

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* **2-5** , 19**49**, *to* **9-12** , 19**49** *that I last saw the deceased alive on* **9-12** 19**49**, *and that death occurred at* **1:05 P.**, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **H. B. Rogers** M. D. | **4940 Eastern Avenue** | **9-19-49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL SEP 22 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 22 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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78335

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078335

TH NO.

NAME OF DECEASED (Type or Print): DAVID McCLENENT WENTWORTH

2. DATE OF DEATH: September 22, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 2900 White Avenue.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 7, 1889 | 60 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Oyster Packing
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.

FATHER'S NAME: Olivier Wentworth
14. MOTHER'S MAIDEN NAME: Katherine Hubbard.

WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO:
17. INFORMANT: Alberta Wentworth (wife) ADDRESS: 2900 White Ave.

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 27 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 21, 1949, to Sept. 22, 1949, *that I last saw the deceased alive on* Sept 22, 1949, *and that death occurred at* 2:24 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A. Spittel, Jr. M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 9/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/24/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 22 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Edwwood Albert Bellingrath

2. DATE OF DEATH September 22/1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Arkansas
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Little Rock
D. STREET ADDRESS (If rural, give location) 42 Edgehill Rd.

Length of stay in Baltimore — Yrs. Mos. Days

| 4. SEX | 5. COLOR OR RACE | 6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 7. DATE OF BIRTH | 8. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 10-8-07 | 41 | | |

| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SECRETARY - MANAGER | Coca-Cola Co. | Alabama | |

FATHER'S NAME: Theodore Bellingrath

14. MOTHER'S MAIDEN NAME: Maude Smith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Glomerulonephritis Uremia | 2 mos unknown |
| DUE TO (B) | Malignant hypertension | 2 mos |
| DUE TO (C) | Glomerulonephritis | unknown |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Schizophrenia | unknown |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7-19 1949 *to* 9-22 1949 *that I last saw the deceased alive on* 9-22 1949 *and that death occurred at* 4 51 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ernest C. Brown Jr. M. D. | JOHNS HOPKINS HOSPITAL | 9/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 22/49 | Rose Lawn | Little Rock, Arkansas |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | John O. Mitchell & Son | 1900 Eutaw Place |

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156 XO

120

78337 ✓ G78337

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Minnie S. Baker

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 109 N. Hilton St.

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22 06
D. STREET ADDRESS (If rural, give location): 109 N. Hilton St.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | July 25, 1873 | 76 | 1 | 26 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Maryland | U.S.A. |

13. FATHER'S NAME: William Downes

14. MOTHER'S MAIDEN NAME: Laura Hartlove

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Katie LaBarrer | 201 Barrow St. |

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease — 4 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March, 1945, *to* Sept 21, 1949, *that I last saw the deceased alive on* Sept. 20, 1949, *and that death occurred at* 6.25 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Gaya M. D. | 3101 W Baltimore St. | 9/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 24, 1949 | Lorraine Park | Balto. County Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | George L. Schwab | 210 Pleasant Ave. |

VS 150

93D

38 ✓x

BALTIMORE CITY HEALTH DEPARTMENT 34.3 G78338

# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Thos. Ford Dre Rutt

2. DATE OF DEATH: Sept. 22, '49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: 4 (Years / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Charleston
D. STREET ADDRESS (If rural, give location): 812 Virginia Ave

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 12-11-34 | 14 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | | W. Va. | |

13. FATHER'S NAME: C. F. Dre Rutt

14. MOTHER'S MAIDEN NAME: Mary Ford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Cardiac Failure | 5 hrs |
| DUE TO (B) | Constrictive Pericarditis, Chronic | |
| DUE TO (C) | | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION: Sept 22 1949

19b. MAJOR FINDINGS OF OPERATION: Constrictive Pericarditis

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 19 1949 *to* Sept 22 1949 *that I last saw the deceased alive on* Sept 22 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Antonia A. Cooley, M. D.

23b. ADDRESS: JOHNS HOPKINS HOSPITAL

23c. DATE SIGNED: Sept 22 '49

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: Sept 23/49

24c. NAME OF CEMETERY OR CREMATORY:

24d. LOCATION (City, town, or county) (State): Charleston W. Va

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry A. Witzke ADDRESS: 401 Edmondson Ave

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678339

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. 678339

H NO.

NAME OF DECEASED (or Print): DORA ROCK

2. DATE OF DEATH: SEPT. 20, 1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1621 E. 32ND ST

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1621 E. 32ND ST.

Length of stay in Baltimore: Yrs. 9 Mos. 06 Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | JAN. 1, 1884 | 65 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: BRAECKLEIN
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: MR. WM F. ROCK — ADDRESS: 1621 E. 32ND ST.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.

DUE TO

(B) Hypertensive Cardiovascular Disease — 4 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1945 *to* Sept 20, 1949, *that I last saw the deceased alive on* Sept 20, 1949, *and that death occurred at* 7:30 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Samuel B McLeffe M. D.
23B. ADDRESS: 133 North Ave
23C. DATE SIGNED: 9-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: SEPT. 24/49
24C. NAME OF CEMETERY OR CREMATORY: MORELAND MEM. PK.
24D. LOCATION (City, town, or county) (State): TAYLOR AVE

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HARRY H WILKES — ADDRESS: 4101 EDMONDSON AVE

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78340 No. 1 G78340

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): ALBERT A. LAVIGNE

2. DATE OF DEATH: 9-21-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2809 Eastern Ave

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2701 Eastern Ave

Length of stay in Baltimore: Life Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 53 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Bessie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lula Lavigne ADDRESS: 2701 Eastern Ave

## CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic Hypertensive Cardio Vascular

DUE TO

(C) Angina Pectoris.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* July 1 1939 *to* Sept 21 1949 *that I last saw the deceased alive on* Wednesday 1949 *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Michael J Lamon Jr M. D. | 2711 Eastern Ave | Sept 22 1949 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-23-49 | Parwood | Bolte Md |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams M.D. | Jack Lewerke | 2100 Eastern Pl |

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BALTIMORE CITY HEALTH DEPARTMENT

H NO. B.C.49-8584 / CERTIFICATE OF DEATH 7 5 ✓ Registered No.

AME OF DECEASED (or Print): JOSEPH CARL SADZENSKI | 2. DATE OF DEATH: SEPT 22-1949

ACE OF DEATH: Baltimore City, Maryland | 2734 ASHLAND AVE

LL NAME OF PITAL OR ITUTION (If not in hospital or institution, give street address or location): HOME

ength of stay in Baltimore: Yrs. Mon. Days

A. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
d. STREET ADDRESS (If rural, give location): 2734 ASHLAND AVE 7-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | 3-18-49 | | 6 | 4 |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | BALTIMORE Md | |

FATHER'S NAME: WALTER A SADZENSKI

14. MOTHER'S MAIDEN NAME: MARIE KOTOWSKI

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | MRS MARIE SADZENSKI | 2734 ASHLAND |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypostatic Pneumonia | Sept 20th 22 |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Congenital Hydrocephalus | 3-18-9-22 |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 18, 19 49, to Sept 22, 19 49, *that I last saw the deceased alive on* Sept 22, 19 49, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| William J. Kramer M. D. | 601 E Kenwood Ave | Sept 22 49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9/23/49 | Holy Rosary | Baltimore - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | George A. Weber | 705 S. Ann st |

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78342

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78342

TH NO.

NAME OF DECEASED (Type or Print): Thomas I. Johnson

2. DATE OF DEATH: 9-21-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hosp.

Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 745 Dolphin Street 17-03

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Colored | Divorced | Sept. 30, 1868 | 81 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer (RET.) | BETH. STEEL Co. | Fraziere, Maryland | |

13. FATHER'S NAME: John T. Johnson

14. MOTHER'S MAIDEN NAME: Emily W.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 219-01-9963

17. INFORMANT — ADDRESS: Dr. James Johnson 745 Dolphin St., Balt. Md

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic acidosis

DUE TO

(B) Diabetes mellitus

DUE TO

(C)

ANTECEDENT CAUSES

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21-49 *to* 9-21-49, *that I last saw the deceased alive on* 9-21, 1949, *and that death occurred at* 6 10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis W. Jasper M. D.

23B. ADDRESS: President Hosp.

23C. DATE SIGNED: 9-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: September 24, 1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial

24D. LOCATION (City, town, or county) (State): Arbutus, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Joseph L. Russ, 1200 McCulloh St., Balt. Md

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3343

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078343

H NO.

1. NAME OF DECEASED (Type or Print) Tilghman Morgan

2. DATE OF DEATH SEP 22 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 1529 Bolton St.

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

5b. Length of stay in Baltimore 51 Yrs. Mos. Days

14-01

| 5c. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb-19-1898 | 51 | | |

10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Real Estate

10b. KIND OF BUSINESS OR INDUSTRY SELF

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John H. Morgan

14. MOTHER'S MAIDEN NAME Mary C. Vickers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 218-16-1038

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | 5 da. |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) acute urinary suppression | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) Anoxia due to pulmonary infarct. | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchiectasis, Carcinoma of liver | |

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9.2. 1949 *to* 9.22 1949, *that I last saw the deceased alive on* 9.22 1949, *and that death occurred at* 2.30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE David Lukens M. D. | 23b. ADDRESS JOHNS HOPKINS HOSPITAL | 23c. DATE SIGNED 9-23-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Sept 24/49 | 24c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | 24d. LOCATION (City, town, or county) (State) Baltimore, Md

25. FUNERAL DIRECTOR ADDRESS Stewart & Mowen Company, 138 W. North Ave. City, #1.

DATE RECEIVED BY LOCAL REGISTRAR SEP 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

46 F

VS 150

8344 X ✓ 678344

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Frank O'Brien Frank Carroll O'Brien

2 DATE OF DEATH Sept. 20, 1949

PLACE OF DEATH: Baltimore City, Maryland University Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

Length of stay in Baltimore 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Prince George
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Laurel
D. STREET ADDRESS (If rural, give location) 212 10th St.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | 5-16-1902 | 47 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY U S Goverment

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Carroll O'Brien

14. MOTHER'S MAIDEN NAME Frances Beck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT Allen O'Brien, Laurel, Md. ADDRESS

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure, acute

DUE TO

(B) Myocardial infarction

DUE TO

(C) Arteriosclerotic & coronary heart dis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 20, 1949, *to* Sept. 20, 1949, *that I last saw the deceased alive on* Sept. 20, 1949, *and that death occurred at* 10 35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Fred R. McClure Jr. M. D.

23B ADDRESS University Hospital

23C DATE SIGNED 9/20

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-24-49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D LOCATION (City, town, or county) (State) Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR DeWitt Donaldson, Laurel, Md. ADDRESS

VS 150

94a

B-131580
G78345
TH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78345

NAME OF DECEASED (or Print): Anna Persol (or Pearsall)

2. DATE OF DEATH: 9-21-1949

PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville (Rural)
D. STREET ADDRESS (If rural, give location): 620 North Bend Road

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

Length of stay in Baltimore: 40yrs. (Yrs. / Mos. / Days)

SEX:
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 3, 1867
9. AGE (In years last birthday): 82 (If under 1 year: Months / Days; If under 1 hour: Hours / Min.)

5. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hair dresser
10a. KIND OF BUSINESS OR INDUSTRY: SELF
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: Charles Glessner (D
14. MOTHER'S MAIDEN NAME: Elizabeth Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records : 4940 Eastern Ave.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion
DUE TO
(B) Hypertensive Cardiovascular Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Fracture neck of L.Femur

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
For Dr. John R. Davis, per
H. B. Forbes M.D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: 9-7-1949
19B. MAJOR FINDINGS OF OPERATION: Fracture neck of L.Femur
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Fell on curb
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): In Catonsville.Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-1-1949 m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell on curb

22. *I hereby certify that I attended the deceased from* 9-3- , 1949 to 9-21- , 1949 *that I last saw the deceased alive on* 9-21- , 1949 *and that death occurred at* 12.30 PM *from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Boyer M.D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-21-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/24/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Mgr
25. FUNERAL DIRECTOR: E. N. MacNabb & Son
ADDRESS:

VS 150
70089

TO BE APPROVED BY THE MEDICAL EXAMINER

186a

B.G.A.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78546

H NO. B.C.49-1842

AME OF DECEASED (Type or Print) Baby Chapman

2. DATE OF DEATH Sept 15 49

LACE OF DEATH: altimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

ength of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 555 Robert St. 14-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Child | Sept 15 49 | | | 1 |

| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

| FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Walter Chapman | Elizabeth Young |

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B) Intracranial hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irene Rheuthin M. D. | JOHNS HOPKINS HOSPITAL | 9-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 23 1949 | Huntington Williams M.D. | |

VS 150

Hospital Disposal

160a

78347 ✓ G78347

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

TH NO.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) | Rebecca McClernon Wrightson |
| 2 DATE OF DEATH | 9/22/49 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 5504 Wexford Rd. |
| Length of stay in Baltimore | 3 years (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A STATE | Md. |
| B COUNTY | --- |
| C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) | Baltimore |
| D STREET ADDRESS (If rural, give location) | 5504 Wexford Road |
| 5 SEX | male |
| 6 COLOR OR RACE | White |
| 7 SINGLE MARRIED WIDOWED DIVORCED (Specify) | Widowed |
| 8 DATE OF BIRTH | 11/28/1873 |
| 9 AGE (In years last birthday) | 75 |
| If Under 1 Year Months Days | 9 24 |
| If Under 24 Hours Hours Min. | -- -- |
| 10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | None |
| 10B KIND OF BUSINESS OR INDUSTRY | None |
| 11 BIRTHPLACE (State or foreign country) | Virginia |
| 12 CITIZEN OF WHAT COUNTRY? | ----- |
| FATHER'S NAME | Samuel Hastings McClernon |
| 14 MOTHER'S MAIDEN NAME | Elizabeth Walker |
| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | ---- ---------- |
| 16. SOCIAL SECURITY NO | ------- |
| 17 INFORMANT | Mrs. Charles D. Luff |
| ADDRESS | 5504 Wexford Rd |

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Pulmonary Emphysema

INTERVAL BETWEEN ONSET AND DEATH

| | |
|---|---|
| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION |
| 20 AUTOPSY? | YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | |
| 21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | |
| 21C WHERE DID INJURY OCCUR? (If in Baltimore City give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | |
| 21E INJURY OCCURRED | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ |
| 21F HOW DID INJURY OCCUR? | |

22. *I hereby certify that I attended the deceased from* 1/ 1 1947, *to* Sept 22, 1949, *that I last saw the deceased alive on* 9/22, 1949, *and that death occurred at* 4:50 P m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
| Albert Rubinstein, M.D. M.D. | 2217 South Road | 9/23/49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) | (State) |
| Burial | 9/24/49 | Springhill | Easton, | Maryland |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
| SEP 23 1949 | Huntington Williams, M.D. | H. H. Means and Son | 805 N. Calvert St. |

VS 150

92D

78548 G78548

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): ANNIE DESETTA RITZIUS

2. DATE OF DEATH: 9-22-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 441 Whitridge Ave.

Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 441 Whitridge Ave. 1703

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Nov. 8, 1854 | 94 yrs. | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Baltimore, Md. | |

13. FATHER'S NAME: Henry Lighthiser

14. MOTHER'S MAIDEN NAME: Elizabeth Debrick

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Minnie D. Roehn | 441 Whitridge Ave |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart disease – 15 yrs. | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 1943, *to* 9-22-49, 1949, *that I last saw the deceased alive on* 9-21, 1949 *and that death occurred at* 1:40 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Hamee Pearce M. D. | Johns Hopkins Hospital | 9-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/24/49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

92D

3549 CERTIFICATE CORRECTED 9-23-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78549

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) ANDREW ~~MICHAEL~~ REESE

2. DATE OF DEATH Sept. 22, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 8 ~~800~~ S. Monestary Avenue 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | white | divorced | Oct 21, 1885 | 63 | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Iron Worker | Wheel Co | MARYLAND | USA |

13. FATHER'S NAME Andrew Reese

14. MOTHER'S MAIDEN NAME Mary Hohman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) No (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 214-01-6859

17. INFORMANT Mrs Katherine Nash ADDRESS Chester Md

## CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Meckels Diverticulitis with perforation

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lobar pneumonia

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23a. SIGNATURE | 23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23c. DATE SIGNED |
|---|---|---|
| William J. McClafferty M.D. | | Sept. 22, 1949 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9/24/49 | Mt Olivet | Frederick Ave Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | John F. Denny Inc. | 715 Light St. |

S 151

108 C.F.N.

G78350

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51 G78350 Registered No.

TH NO.

NAME OF DECEASED (or Print) John M. Mertel or Michael J. Mertel

2. DATE OF DEATH Sept 21-49

PLACE OF DEATH: Baltimore City, Maryland Balto. Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 S CHAPEL ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 31 S. Chapel St 2-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 3 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Printer | Printing | Balto. | U.S.A. |

13. FATHER'S NAME Jacob Mertel

14. MOTHER'S MAIDEN NAME ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | 215-03-9145 | Anna M. Mertel | 31 S. Chapel St |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Malnutrition | 2 weeks |
| DUE TO (B) | Metastasis gastric carcinoma (?) | not known |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* August 5 1949, to Sept 21, 1949, *that I last saw the deceased alive on* Sept 20 1949, *and that death occurred at* 10 20 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles D. MacMinn M. D. | 2911 E. Baltimore St. | Sept 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT 24 1949 | HOLY REDEEMER CEM. | 4430 BELAIR ROAD MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | Diffpel Bros | 1800 E LOMBARD ST. |

VS 150

463

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 178351

1. NAME OF DECEASED (Type or Print): Thelma Stepter STEPTER
2. DATE OF DEATH: 9/23-49
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: Md B. COUNTY: Balto
C. CITY OR TOWN: Balto (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1830 Pa. ave
FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location) John Hopkins Hospital
Length of stay in Baltimore: Yrs. 1 Mos. Days
SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Balto-Md
9. AGE (In years last birthday): 24
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Edith Bowen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Husband Stepter ADDRESS: (Husband)

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma Uterus | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: 3 Mo. prior 19B. MAJOR FINDINGS OF OPERATION: Jonathan at Hopkins - 2 mo 49
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 7/ 49, *to* 9/23 49, *that I last saw the deceased alive on* 9/22 49 *and that death occurred at* 4 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Bk R Leetts M. D.
23B. ADDRESS: 213 E Hoffman
23C. DATE SIGNED: 9/23-49
24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/26/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus
24D. LOCATION (City, town, or county) (State): Md
DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams MD
25. FUNERAL DIRECTOR: Ged. A. Kelson ADDRESS: 1303

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552

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78,552

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Harry Cassell

2. DATE OF DEATH Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland Med Det 6

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1202 W. Baltimore St

Length of stay in Baltimore 05 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Sep. | 4-1-87 | 62 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard
10B. KIND OF BUSINESS OR INDUSTRY PROVING GROUNDS - MILITARY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Cassell
14. MOTHER'S MAIDEN NAME Ellen Price
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Myocardial infarction | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Coronary atherosclerosis | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic obstructive pneumonitis | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9-8-, 1949 *to* 9-21-, 1949, *that I last saw the deceased alive on* 9-21-, 1949, *and that death occurred at* 3:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE Walter Brown M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/23/49
24C. NAME OF CEMETERY OR CREMATORY Baltimore National
24D. LOCATION (City, town, or county) (State) 5500 Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR SEP 23 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Schumacher Funeral Home Inc.

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WALTER BROWN

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553

TH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78553

NAME OF DECEASED (Type or Print): Ida Raisin

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 706 ½ W. Saratoga St.

Length of stay in Baltimore: Yrs. 4 Mos. - Days 0

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 706 ½ W. Saratoga ST.

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | May 29 1896 | 53 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto. Md | U.S.A. |

13. FATHER'S NAME: James Mc Gray

14. MOTHER'S MAIDEN NAME: Mary ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | — | George Raisin | 706 ½ W. Saratoga St. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 30 min |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Hypertensive cardiovascular renal disease. | Unknown |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 12, 1949, *to* Sept 21, 1949, *that I last saw the deceased alive on* July 21, 1949, *and that death occurred at* 5 35 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Leland Sherrill Jr. M. D. | 902 W. Franklin | 9-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-25-1949 | W. H. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams M.D. | Mc Katai R. Williams | 3224 Edmondson Ave |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

TH NO. B.C. 49-19509 Registered No.

NAME OF DECEASED (Type or Print): Baby Girl Ringgold

2. DATE OF DEATH: 9/21/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. of Md.

Length of stay in Baltimore: 9 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen Md.
D. STREET ADDRESS (If rural, give location): Aberdeen

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | Under 1 Year: Months | Days | Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | | 9/12/49 | | | 9 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto | U.S.A. |

13. FATHER'S NAME: Robert Grinage
14. MOTHER'S MAIDEN NAME: Flossie Ringgold
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Robert Grinage ADDRESS: Aberdeen Md.

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Prematurity

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Duncan Schwartz M. D. | Univ. of Md. | 9/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-23-1949 | W. Antrim Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 3221 Edmondson |

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157E

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78555

TH NO. B.C. 49-09211

NAME OF DECEASED (Type or Print): Calvin Gerald Harris

2. DATE OF DEATH: Sept. 20, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 938 W. Saratoga St. 18-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Col. | Single | April 26, 1948 | 1949 | 4 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Donald Bernard Pinacle
14. MOTHER'S MAIDEN NAME: Faith Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): ***
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Myrtle Harris, ADDRESS: 938 W. Saratoga St.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Interstitial Pneumonia | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-23-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams Schwindel
ADDRESS: 3224

VS 151

114E

356 ✓X Bowie 45 6

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078356

TH NO.

NAME OF DECEASED (Type or Print): Mary E Bowie

2. DATE OF DEATH: 9/22/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp

Length of stay in Baltimore: 24 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Frederick
D. STREET ADDRESS (If rural, give location): 40 Lincoln Apts

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Married | Sept 30 1919 | 29 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Robertson
14. MOTHER'S MAIDEN NAME: Alice Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Disseminated Lupus Erythematosus

DUE TO

(B) Pneumonitis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/30, 1949 *to* 9/22, 1949 *that I last saw the deceased alive on* 9/22, 1949, *and that death occurred at* 8:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE: L. Richard Fravel M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 9/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 26, 1949
24C. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24D. LOCATION (City, town, or county) (State): Frederick, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. R. Eichmuller & Son
ADDRESS:

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G78557 CERTIFICATE CORRECTED 9-26-49 V G78557

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): WILSON - Sadie E.

2. DATE OF DEATH: 9-21-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 605 ~~606~~ S. Hanover 2 2 - 01

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Oct. 18, 1884 | 64 ~~65~~ | | |

10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Andrew N. Kreamer ADDRESS: New Cut Road Severn Md.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular Accident

DUE TO

(B) Hypertensive CVD

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: no
19B. MAJOR FINDINGS OF OPERATION: no
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21, 19 49 *to* 9-21, 19 49 *that I last saw the deceased alive on* 9-21 19 49 *and that death occurred at* 5 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: James M. Bisanar M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 9-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/26/49
24C. NAME OF CEMETERY OR CREMATORY: U.S. National
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. M. Cook Inc. ADDRESS: 127 St. Paul St.

93D

G78358 G78358

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

H NO.

1. NAME OF DECEASED (Type or Print): Hannah L. Gaskhardt

2. DATE OF DEATH: 9/24/49 - 10 45 a.m.

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4705 Amberley Ave

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto
D. STREET ADDRESS (If rural, give location): 4705 Amberley Ave 28-04

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 3/30/1864 | 85 | 5 | 21 |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Bal., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Connor

14. MOTHER'S MAIDEN NAME: Unknown, Mont 4705 Amberley Ave

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Edgar A. Gaskhardt ADDRESS: 4705 Amberley Ave

## 18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16, 1949 *to* Sept 24, 1949, *that I last saw the deceased alive on* Sept 20, 1949, *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert Seagmuller M. D.

23B. ADDRESS: 1729 W. Lombard St.

23C. DATE SIGNED: 9/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9/24/49

24C. NAME OF CEMETERY OR CREMATORY: Balto.

24D. LOCATION (City, town, or County) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: 9.3.1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: H. Poole Inc. ADDRESS: 1217 St. Paul St.

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92)

G78359 G78359

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 443

TH NO.

NAME OF DECEASED (Type or Print) Raymond Bernard Collier

2. DATE OF DEATH September 21, 1949

PLACE OF DEATH: Baltimore City, Maryland Baltimore, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 435 Evesham Avenue

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 435 Evesham Avenue 2 7 12

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| ale | white | married | Oct. 8, 1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| -k | Bleck & Decker | Baltimore, Maryland | |

13. FATHER'S NAME Otis P. Collier

14. MOTHER'S MAIDEN NAME Mary Ward

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Sadie Collier, 435 Evesham Avenue |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 6 hrs |
| | DUE TO (B) Hypertension and Valvular Heart Disease | 5 yrs. 7 mos. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 2-7, 1945 *to* 9-21, 1949 *that I last saw the deceased alive on* 9-21, 1949 *and that death occurred at* 4:00 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. T. Cole M. D. | 6014 York Road | 9-21-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 9/24/49 | Baltimore | Baltimore Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 23 1949 | Huntington Whitehead, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

927

G78360

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 G78360 Registered No.

TH NO.

NAME OF DECEASED (Or Print) Eva Madison

2. DATE OF DEATH Sept. 22/49

PLACE OF DEATH: Baltimore City, Maryland Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 1200 Valley St.

Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Md.
D. STREET ADDRESS (If rural, give location) 1200 Valley St 10-01

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wd.
8. DATE OF BIRTH Sept 16, 1882
9. AGE (In years last birthday) 67 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10a. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME Adam Bridges
14. MOTHER'S MAIDEN NAME Marg. Ellicott

WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or Unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Sis-Jones ADDRESS 1200 Valley St

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Edema Lungs | 1 day. |
| DUE TO (B) | Cerebral Hemorrhage | 1 week. |
| DUE TO (C) | Arterio-Sclerosis | 5 yrs. |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 19 49, to Sept 22, 19 49, that I last saw the deceased alive on Sept 22, 19 49, and that death occurred at 7:40 p.m., from the causes and on the date stated above.

23A. SIGNATURE E. Gill Hall M. D.
23B. ADDRESS 1631 E. North ave
23C. DATE SIGNED Sept 23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9/24/49
24C. NAME OF CEMETERY OR CREMATORY Cathedral
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Otto Wiedefeld
ADDRESS 900 E. Biddle St

VS 150

83a

G78561

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31

G78561 Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Joyce Romaine Lark

2. DATE OF DEATH 9-21-44

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

Length of stay in Baltimore: Yrs. Mos. Days — 2 days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Carol
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hampstead
D. STREET ADDRESS (If rural, give location) R.F.D. #3

| 3. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 11/14/43 1943 | 6 | 10 | 2 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child — 10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto., Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

FATHER'S NAME Joy Lark — 14. MOTHER'S MAIDEN NAME Bonnie Wolf

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO —

17. INFORMANT — ADDRESS Childrens Aid Society, Carroll Co.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH— (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral damage — INTERVAL BETWEEN ONSET AND DEATH: 60hrs.

DUE TO

(B) Cerebral anoxia

DUE TO

(C) Cardio - respiratory arrest (5 min.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION 9-14-44 — 19B. MAJOR FINDINGS OF OPERATION Hypertrophied tonsils + adenoids — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 18 1944 *to* Sept. 21, 1944 *that I last saw the deceased alive on* Sept. 21, 1944, *and that death occurred at* 10 30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE F. Robert Haase M. D. — 23B. ADDRESS University Hospital — 23C. DATE SIGNED 9-22-44

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE 9/25/44 — 24C. NAME OF CEMETERY OR CREMATORY Millers Mem. — 24D. LOCATION (City, town, or county) (State) Millers, Carroll Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 29 1944 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS Jacob Winks Son, Manchester, Md.

115c

078562

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078562

1. NAME OF DECEASED (Type or Print): Mary E. Hart
2. DATE OF DEATH: Sept. 21 1949

3. PLACE OF DEATH: Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1201 Druid Hill Ave.
Length of stay in Baltimore: 1 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1201 Druid Hill Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widow | 7/6/85 | 64 | | | | |

10A. USUAL OCCUPATION (Give kind of work during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): East. D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mary Brooks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Alice Fowler ADDRESS: 1201 Druid Hill Ave

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Degeneration | Unk. |
| DUE TO (B) | Malignant Hypertension | — |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-22, 1949 to 9-21, 1949, that I last saw the deceased alive on 9-21, 1949, and that death occurred at 10 a.m. p.m., from the causes and on the date stated above.

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 1543 Bennett Ave
23C. DATE SIGNED: 9/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 24 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1601 Druid Hill Ave.

93D

78363

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78363

TH NO.

NAME OF DECEASED (Type or Print) MR. STANLEY C. CARMAN.

2. DATE OF DEATH 9/22/49.

PLACE OF DEATH: a. Baltimore City, Maryland b. COUNTY Church Home & Hosp.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore. 12-07
d. STREET ADDRESS (If rural, give location) 2937 St. Paul Street.

Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower. | 2/4/1875 | 74 yrs. | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| (Retired) ASST. MGR | THEATER | Baltimore. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Elijah Leaman. | Elizabeth Kerr. |

| WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| (no or unknown) | | Miss Carrie Carman | 2937 St. Paul St. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Coronary Occlusion. | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| (B) | Arteriosclerotic Heart | |
| DUE TO | Disease. | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11 AM 9/22 1949 *to* 3.20 PM 9/22 1949 *that I last saw the deceased alive on* 9/22 1949 *and that death occurred at* 3.30 p. m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Richard M. Garrett M. D. | Church Home & Hosp | 22 Sept 49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/24/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

978364 BALTIMORE CITY HEALTH DEPARTMENT 163-5 978364

TH NO. B.C. 4919439 CERTIFICATE OF DEATH Registered No.

| | | |
|---|---|---|
| AME OF DECEASED (e or Print) Baby Girl Meade | 219803 | 2. DATE OF DEATH September 12, 1949 |
| LACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY | |
| ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| Length of stay in Baltimore Yrs. 0 Mos. Days | D. STREET ADDRESS (If rural, give location) 123 South Caroline Street | 3-01 |

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| ale | Negro | Single | September 12, 1949 | | | | 12 | 18 |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

| FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ifton Barnes | Dorothy Meade |

| WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | The Johns Hopkins Hospital | 601 N. Broadway |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Intrauterine pneumonia | 14 hrs |
| DUE TO (B) | Premature Rupture of membranes | 14 hrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Premature labor | 16 hrs |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Immaturity, fetal weight 475 gms | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| No operation | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | no injury | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Sept. 12, 1949 *to* Sept. 12, 1949, *that I last saw the deceased alive on* Sept. 12 1949, *and that death occurred at* 1:12 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Andreano M. D. | 601 N. Broadway | 9-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Loch Raven | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Huntington Williams, M.D. | | |

VS 150

160c

78365 BALTIMORE CITY HEALTH DEPARTMENT E902.6 G78365

# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): AUGUSTUS L. RILEY N-804 r

2. DATE OF DEATH: September 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 516 S. Madeira Street 1-04

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9/17/28 | 21 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Window Washer
10a. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Riley
14. MOTHER'S MAIDEN NAME: Stella ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: ?

17. INFORMANT: William Yeager ADDRESS: 2537 Fleet Ave

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture, Skull

DUE TO

(B) Subarachnoid hemorrhage

DUE TO

(C) Fracture, femur, right

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Fracture - Dislocation, 1st lumbar vertebra

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Office Building
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Rear of 218 Water Street 4-1
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Sept. 21, 1949 10:30 A. m.
21E. INJURY OCCURRED: WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? While washing window, lost balance and fell from 4th story

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 9-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: 9/26/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 23 1949
REGISTRAR'S SIGNATURE: Euretta Jon Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Jones ADDRESS: 405 W. Fayette St.

186a

78366 G78366

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 171 G78366

TH NO.

NAME OF DECEASED (or Print) Florence Lidard

2. DATE OF DEATH 9-23-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

Length of stay in Baltimore 18 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2831 O'Donnell St. 1-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | Married | Aug. 29, 1913 | 36 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Brown (D)
14. MOTHER'S MAIDEN NAME Jennie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. ?
17. INFORMANT RECORDS BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | |
| DUE TO | | |
| ANTECEDENT CAUSES | (B) Carcimona of the Cervix | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-27, 1949, *to* 9-23, 1949 *that I last saw the deceased alive on* 9-23, 1949, *and that death occurred at* 3:30 A., *from the causes and on the date stated above.*

23A. SIGNATURE J. R. Bogan M. D.
23B. ADDRESS 4940 Eastern Avenue
23C. DATE SIGNED 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 9/26/49
24C. NAME OF CEMETERY OR CREMATORY St MATTHEWS
24D. LOCATION (City, town, or county) (State) BALTO. MD.
25. FUNERAL DIRECTOR Lilly & Zeller Inc. ADDRESS Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26
REGISTRAR'S SIGNATURE Hamilton for Williams, M.D.

VS 150

48a

BS 81964
78367

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 33

G78367
Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Annie Adams

2. DATE OF DEATH: 9-22-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hospitals

Length of stay in Baltimore: 21 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 17-01
D. STREET ADDRESS (If rural, give location): 517 W. Biddle (570 E. Biddle)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | Jan. 18 ? | 65? | | |

| 9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

FATHER'S NAME: Wesley Adams (D)

14. MOTHER'S MAIDEN NAME: Katie Williams

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | RECORDS*BALTO. CITY HOSPITALS | 4940 EASTERN AVE. |

## CAUSE OF DEATH

18.

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] Yes NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 6-10, 1943, *to* 9-22-, 1949 *that I last saw the deceased alive on* 9-22, 1949, *and that death occurred at* 11:40 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M.D. | 4940 Eastern Ave. | 9-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 24 1949 | Int Auburn | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 24 1949 | Huntington Williams, MD | Holland Funeral Home | |

VS 150

838

78568 — BALTIMORE CITY HEALTH DEPARTMENT — 181 — G78568

# CERTIFICATE OF DEATH

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): DAISY M. RAYMO

2. DATE OF DEATH: 9/22/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

Length of stay in Baltimore: 52 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO - 17 14-01
D. STREET ADDRESS (If rural, give location): 1411 LINDEN Av

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | White | Widowed | 9/18/1882 | 67 | 0 | 2 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: House wife

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Dennis Fogle

14. MOTHER'S MAIDEN NAME: Elizabeth Wright well

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Harry Greenholtz
ADDRESS: 4806 Reisterstown Rd

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Bladder
DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.
(B)
DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1949, to Sept, 1949, *that I last saw the deceased alive on* Sept. 22, 1949, *and that death occurred at* 6:45 Am., *from the causes and on the date stated above.*

23A. SIGNATURE: John F. Strahan M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 9/22/49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial
24B. DATE: 9/24/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Union Bridge
24D. LOCATION (City, town, or county) (State): Carroll Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 127 St. Paul st.

VS 150

52B

G78369

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50.1 G78369

TH NO. _____ Registered No. _____

NAME OF DECEASED (Type or Print): Mary Susan McCall

2 DATE OF DEATH: Sept 22, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

Length of stay in Baltimore: Yrs. _____ Mos. _____ Days _____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Street, Maryland
D. STREET ADDRESS (If rural, give location):

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | March 13 1860 | 89 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.

FATHER'S NAME: Josiah Almony
14. MOTHER'S MAIDEN NAME: Margaret Duncan

WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Hospital Record ADDRESS: U. M. H.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxemia, age — INTERVAL BETWEEN ONSET AND DEATH: Unknown
DUE TO
(B) Appendicial abscess —
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Sept. 17, 1949 | Appendiceal Abscess | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____ 19__, *to* _____, 19__, *that I last saw the deceased alive on* Sept 22 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis D Watt M. D. | Union Memorial Hosp. | Sept. 22. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 9/26/49 | Wesley Chapel | Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 24 1949 | Huntington Williams, MD | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

121

78370 — BALTIMORE CITY HEALTH DEPARTMENT — G78370

# CERTIFICATE OF DEATH

TH NO. — Registered No.

NAME OF DECEASED (Type or Print): CHARLES AUGUSTUS SMITH

2. DATE OF DEATH: Sept. 23, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hosp.

Length of stay in Baltimore: Life 66 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15-47
D. STREET ADDRESS (If rural, give location): 2915 WINDSOR Ave 4/6

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Sept. 19, 1883 | 66 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yardmaster (rtd)
10B. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Baltimore MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A

FATHER'S NAME: HARRY Clay Smith
14. MOTHER'S MAIDEN NAME: EMMA BRADLEY

WAS DECEASED EVER IN U. S. ARMED FORCES? (yes or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Katherine C. Smith — ADDRESS: 2915 WindsorAve

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 10 days |
| DUE TO (B) | Cerebrovascular accident | 12 days |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/13, 1949, *to* 9/23, 1949, *that I last saw the deceased alive on* 9/23, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mark E Hall, M. D.
23B. ADDRESS: U of Md Hosp.
23C. DATE SIGNED: 9/2[illegible]/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/27/49
24C. NAME OF CEMETERY OR CREMATORY: Immanuel Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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78371 ✓ 331 978371

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

TH NO. Registered No.

NAME OF DECEASED (Type or Print): CECELIA MARIE FONSHELL

2. DATE OF DEATH: Sept. 22, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 712 E. North Ave.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 712 E. North Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | ? | Dec. 1, 1869 | 79 yrs. | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

FATHER'S NAME: John Gannon
14. MOTHER'S MAIDEN NAME: Rose Duran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: no
17. INFORMANT: Miss A. Elizabeth Fonshell ADDRESS: 712 E. North Ave.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 4 Days |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) General Arteriosclerosis and Antecedent Hypertension | 2 years |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 20 1949 *to* Sept 22 1949, *that I last saw the deceased alive on* Sept 22 1949, *and that death occurred at* 11.45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Albert Cisenberg M. D.
23B. ADDRESS: 8025 East North Ave.
23C. DATE SIGNED: 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/26/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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78372 ✓ 420 1 G78372

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): ROBERT FRANK BALLARD

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3702 Clifton Ave.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-48
D. STREET ADDRESS (If rural, give location): 3702 Clifton Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | Feb. 24, 1899 | 50 yrs. | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Building Materials | Self | Baltimore, Md. | |

13. FATHER'S NAME: William C. Ballard

14. MOTHER'S MAIDEN NAME: Roberta Franklin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Wm. C. Ballard | 3702 Clifton Ave. |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardiovascular disease | about 4 yrs. |
| DUE TO | coronary occlusion | about 10 min. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 16, 1949, *to* Sept 21, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter L. Wilson M. D. | 2220 Harrison Blvd. | Sept 23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/24/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 24 1949 | Hunter for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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G78373 BALTIMORE CITY HEALTH DEPARTMENT 760-5 G78373

# CERTIFICATE OF DEATH

Registered No.

TH NO. DC-49-2921

NAME OF DECEASED (Type or Print): Baby Girl Thenhauser

2. DATE OF DEATH: Sept. 23, 1949

PLACE OF DEATH: Baltimore City, Maryland — Gv. Harnet Lane

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-07
D. STREET ADDRESS (If rural, give location): 2801 Louise Ave

Length of stay in Baltimore: Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | 9-21-49 | | | 23 |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | | Md | |

13. FATHER'S NAME: Robert Thenhauser

14. MOTHER'S MAIDEN NAME: Margaret O'Keefe

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | 2 d |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Intra-cranial hemorrhage. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/22, 1949, to 9/23, 1949, *that I last saw the deceased alive on* 9/23, 1949, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irene R Swenton M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-24-49 | New Cathedral | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 24 1949 | Huntington Williams, M.D. | Leonard J Luck - 6305 | Harford |

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Dr. Brill
1221 N. Luzerne

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78374

STH NO.

| | | | |
|---|---|---|---|
| NAME OF DECEASED (Type or Print) | Mary A.W. O'Connor (Wellie Connor) | 2 DATE OF DEATH | Sept. 23, 1949 |

3. PLACE OF DEATH: Baltimore City, Maryland
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4137 Marx Avenue
Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 4137 Marx Avenue

| 5 SEX | 6. COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Widowed | July 19, 1868 | 81 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Baltimore, Maryland | |

| FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| William F. Larkin | Mary A. James |

| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Agnes Wilson | 7003 Linden Ave. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary occlusion | 4 hrs |
| DUE TO (B) | Coronary artery disease | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | generalized arteriosclerosis | ? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Senility | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 22, 1949, *to* Sept. 23, 1949, *that I last saw the deceased alive on* Sept 23, 1949, *and that death occurred at* 9 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Brill M. D. | 1221 N. Luzerne Ave | Sept. 23, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-27-49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 24 1949 | Huntington Williams, M.D. | Leonard J. Buck, | 3805 Harford Road. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

6 / 0 Registered No. 978375

STATE NO.

NAME OF DECEASED (Type or Print) ADAM KNIERIM

2. DATE OF DEATH 9-23-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-34
D. STREET ADDRESS (If rural, give location) 6204 BELAIR Rd. #6

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | Married | 6-21-1870 | 99 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR
10B. KIND OF BUSINESS OR INDUSTRY (SELF)
11. BIRTHPLACE (State or foreign country) GERMANY
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME JACOB KNIERIM
14. MOTHER'S MAIDEN NAME ELIZABETH Schick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT HELENE KNIERIM ADDRESS SAME

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) SHOCK - POST OPERATIVE | 2 days |
| ANTECEDENT CAUSES | DUE TO (B) BENIGN PROSTATIC HYPERTROPHY | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CIRRHOSIS OF LIVER, MYOCARDIAL DEGEN | |

19A. DATE OF OPERATION 9-20-49
19B. MAJOR FINDINGS OF OPERATION BENIGN PROSTATIC HYPERTROPHY - URINARY RETENTION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22-, 1949, *to* 9-23, 1949 *that I last saw the deceased alive on* 9-23 1949 *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS Maryland Gen. Hosp.
23C. DATE SIGNED 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-26-49
24C. NAME OF CEMETERY OR CREMATORY Woodlawn
24D. LOCATION (City, town or county) (State) Balto Md
25. FUNERAL DIRECTOR Leonard J. Luck ADDRESS 5305 Harford.

DATE RECEIVED BY LOCAL REGISTRAR SEP 24 1949
REGISTRAR'S SIGNATURE Counter for Nathanson, M.D.

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BALTIMORE CITY HEALTH DEPARTMENT 1949

# CERTIFICATE OF DEATH

Registered No. G78376

CITY NO.

1. NAME OF DECEASED (Type or Print): May Russell Slagle

2. DATE OF DEATH: Sept-23-1949

PLACE OF DEATH: Baltimore City, Maryland 4803 Roland Avenue

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home

Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 4803 Roland Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | Married | Nov-15-1875 | 73 years | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Alex. H. Russell

14. MOTHER'S MAIDEN NAME: Amelia Keach

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Charles W. Slagle (husband) | Balto. Md. |

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized and coronary atherosclerosis with chronic heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4-5 yrs

DUE TO

(B) Metastatic carcinoma of pelvis and probably bladder - primary site undetermined

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan, 1944 *to* Sept, 1949, *that I last saw the deceased alive on* Sept 22, 1949, *and that death occurred at* 9.50 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter B. Buck M. D. | 18 E. Eager St Balto-2 | Sept 23, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept-26-1949 | Greenmount Cemetery | Baltimore City, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 24 1949 | Hunter for Williams, M.D. | Stewart & Mowen Co., | 108 W. North Avenue |

VS 150

City #1.

55E

78577 | 70 | 78577

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Katie Frey

2. DATE OF DEATH: Sept 22-49

PLACE OF DEATH: Baltimore City, Maryland — Balto

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4515 Garrison Blvd — Towson Nursing Home

Length of stay in Baltimore: Balto — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Md
D. STREET ADDRESS (If rural, give location): 2830 Lake ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan 30-1873
9. AGE (In years last birthday): 76 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cleanswoman
10B. KIND OF BUSINESS OR INDUSTRY: May Co
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frederich Frey
14. MOTHER'S MAIDEN NAME: Mary Doety

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 247-07-3784
17. INFORMANT: Mrs Frederick Frey
ADDRESS: 2830 Lake ave

## CAUSE OF DEATH

16.

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the breast

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B)

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 6, 1949, to Sept 22, 1949, *that I last saw the deceased alive on* Sept 21, 1949, *and that death occurred at* 10 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. H. Cutterman, M. D.
23B. ADDRESS: 2324 Reisterstown Rd
23C. DATE SIGNED: 9/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 26-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Jos J. Herr & Son
ADDRESS: 3001 Kentucky ave

VS 150

50

G78578

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

75-45 Registered No. G78578

1. NAME OF DECEASED (Type or Print): Robert Kyle
2. DATE OF DEATH: Sept. 23 1949
3. PLACE OF DEATH: Baltimore City, Maryland — 2H 2
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: D.C. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 1805 Bay St.
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
Length of stay in Baltimore: Yrs. Mos. Days
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 3-5-1949
9. AGE (In years last birthday): If Under 1 Year Months: 6 Days: 18 If Under 24 Hours Hours: Min:
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10a. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Hershel Kyle
14. MOTHER'S MAIDEN NAME: Leola Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Tracheal Obstruction | 10 min. |
| DUE TO | Congenital Anomaly of Great Vessels: | |
| (B) | Right Aortic Arch with Left descending aorta; | Since birth. |
| (C) | aortic arch posterior to trachea. Obstruction intermittent. | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-18-, 1949 *to* 9-23-, 1949 *that I last saw the deceased alive on* 9-23-, 1949 *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas C. McPherson M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 9/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 25 1949
24C. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
24D. LOCATION (City, town, or county) (State): Bladensburg Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. William Lee Sons Co.
ADDRESS: 300 4½ St. N.W. 157E Washington, D.C.

VS 150

8379

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078379

STATE NO.

NAME OF DECEASED (Type or Print): WILLIAM McPHERN

2. DATE OF DEATH: Sept. 21, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-02
D. STREET ADDRESS (If rural, give location): 1230 Madison St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Widowed | Mar 7-1857 | 92 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NC
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lena Johnson ADDRESS: 1238 E Madison St

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic cardiovascular disease | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 9/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/24/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A-2 Co Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 931 1412 E. Preston St

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G78380

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78380

NO.

1. NAME OF DECEASED (Type or Print): Laura Etta Thompson

2. DATE OF DEATH: September 24, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U S Marine Hospital, Baltimore, Md.

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chevy Chase,
D. STREET ADDRESS (If rural, give location): 17 Virgilia St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Widow | Feb. 6, 1864 | 85 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): LaFayette, Ind.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Steuben
14. MOTHER'S MAIDEN NAME: Elizabeth Kemp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown): --
(If yes, give war or dates of service): --
16. SOCIAL SECURITY NO:
17. INFORMANT: Records - U S Marine Hospital
ADDRESS:

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia, purulent, rt lower lobe, left lower lobe | unknown |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) | Fibrosis, rt. upper lobe | unknown |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis, generalized aorta, brain, heart, kidney | unknown |
| | Diverticulosis, descending & sigmoid colon | unknown |

19A. DATE OF OPERATION: --
19B. MAJOR FINDINGS OF OPERATION: --
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 25, 1946 *to* Sept. 24, 1949, *that I last saw the deceased alive on* Sept. 24 19 49 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Clinical Dir. Med. Dir. M. D.
ADDRESS: U S Marine Hospital, Balto., Md.
23C. DATE SIGNED: 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 27-Sept. 49
24C. NAME OF CEMETERY OR CREMATORY: Federal Hill Crematory
24D. LOCATION (City, town, or county) (State): Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 24 1949 VS 150
REGISTRAR'S SIGNATURE: Turrington Williams, M.D.
25. FUNERAL DIRECTOR: Robert Pumphrey
ADDRESS: Bethesda

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G78381

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153 G78381

Registered No.

TH NO. G78381

NAME OF DECEASED (Type or Print): Oliver P. Jacobs

2. DATE OF DEATH: Sept. 23, 1949

PLACE OF DEATH: Baltimore City, Maryland

1668 Cliftview Ave.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1668 Cliftview Ave.,

Length of stay in Baltimore: Yrs. 8 Mos. 0 Days 5

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 7, 1876 | 73 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron moulder

10B. KIND OF BUSINESS OR INDUSTRY: Navy Yard

11. BIRTHPLACE (State or foreign country): York, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore R. Jacobs

14. MOTHER'S MAIDEN NAME: Christina Bufflays

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Florence Jacobs ADDRESS: 1668 Cliftview Ave.

## 18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal obstruction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Ascending Colon Metastasis

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: August 28, 1949

19B. MAJOR FINDINGS OF OPERATION: Carcinoma of ascending colon inoperable.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 22nd, 1949 *to* September 23, 1949 *that I last saw the deceased alive on* Sept. 22nd, 1949, *and that death occurred at* 8:30 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: W. Edward Wells M. D.

23B. ADDRESS: 3000 St Paul St Baltimore

23C. DATE SIGNED: Sept. 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: Sept. 25, 1949

24C. NAME OF CEMETERY OR CREMATORY: Prospect Hill

24D. LOCATION (City, town, or county) (State): York, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 25 1949

REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.

25. FUNERAL DIRECTOR: Ullrich Funeral Home ADDRESS: 2008 Orleans St.,

46E

G78382 ✓ X 581 G78382

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Charles Long

2 DATE OF DEATH: 9/24/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Texas
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 5/10/1904 | 45 | | |

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Long
14. MOTHER'S MAIDEN NAME: Dora Tandrop
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Bernard Long ADDRESS: Texas, Md.

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirhosis of the liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
II DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/19/49, 19__, *to* 9/24, 1949 *that I last saw the deceased alive on* 9/24, 1949 *and that death occurred at* 11 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert J. Kivickas M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 27, 1949
24C. NAME OF CEMETERY OR CREMATORY: Poplar
24D. LOCATION (City, town, or county) (State): Cockeysville, Md

DATE RECEIVED BY LOCAL REGISTRAR: 9 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lansdale M. Brooks ADDRESS: 124B Sparks, Md

VS 150

G78583

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78583

STH NO. 6'0 Registered No.

NAME OF DECEASED (Type or Print): Rixson Robbins Cobb

2. DATE OF DEATH: 9/24/49

PLACE OF DEATH: Baltimore City, Maryland — Balto, Md.

FULL NAME OF HOSPITAL OR INSTITUTION: U. S. Marine Hosp. (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: 15 Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Port Norris
D. STREET ADDRESS (If rural, give location): —

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | Oct 17, 1880 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Cobb
14. MOTHER'S MAIDEN NAME: Mary Bailey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unk
17. INFORMANT: Marine Hosp. Record — ADDRESS

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arterio-sclerotic Cardio-Vas- | |
| | DUE TO cular disease, with | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) arteric insufficiency, Prostatectomy, post | |
| | DUE TO operative state. | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION: 9/15/49
19B. MAJOR FINDINGS OF OPERATION: B. G. H
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Post Operative
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 9/9, 1949, *to* 9/24, 1949 *that I last saw the deceased alive on* 9/24, 1949, *and that death occurred at* 4:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman Carr, M. D.
23B. ADDRESS: Marine Hosp.
23C. DATE SIGNED: 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 24/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Port Norris N.J.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Mitchell Sr.
ADDRESS: 190 Eutaw Place

137a

G78584 G78584

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Georgiana A Davidson Simpson
2. DATE OF DEATH: Sept. 23/49.

3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 306 Thackery Rd.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
Length of stay in Baltimore: 8 yrs. (Yrs. / Mon. / Days)

5. SEX: female
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: MAR. 17. 1915
9. AGE (In years last birthday): 33
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10a. KIND OF BUSINESS OR INDUSTRY: U. S. Govt.
11. BIRTHPLACE (State or foreign country): West Plains Mo.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lemming Davidson
14. MOTHER'S MAIDEN NAME: Frances Burnet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: W. Clyde Simpson ADDRESS: 306 Thackery Rd Cat. Md.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain abscess
DUE TO
(B) Pneumonia
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 22 Sept 1949
19B. MAJOR FINDINGS OF OPERATION: Brain abscess left parietal lobe
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 Sept, 1949 *to* 23 Sept, 1949, *that I last saw the deceased alive on* 23 Sept, 1949, *and that death occurred at* 3:32 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jose A Alvarez de Choudens M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 23 Sept/1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 9/24/49
24C. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24D. LOCATION (City, town, or county) (State): Norfolk Va.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 25 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Leitzke ADDRESS: 4101 Edmondson Ave.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

57 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Magdalena E. Johnson

2. DATE OF DEATH: Sept. 23, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3620 Beech Avenue

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3620 Beech Avenue 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | March 4, 1913 | 36 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waitress | ODD Jobs | Baltimore, Maryland | U S A |

13. FATHER'S NAME: George Hemerka

14. MOTHER'S MAIDEN NAME: Susanna Stefan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 213-10-7418 | Mrs. Susanna Hemerka | 3620 Beech Avenue |

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, pancreas — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| About Dec. 1948 | Carcinoma, pancreas | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* Sept 23, 1949 *that I last saw the deceased alive on* Sept 22, 1949, *and that death occurred at* 5 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. N. McFaul Jr M. D. | 1800 N. Charles St | 9/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 26, 1949 | Holy Redeemer | Baltimore, Maryland |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 25 1949 | [illegible] | Burgee Funeral Home | 3631 Falls Road |

SEP 25 1949 78071 Transcription Williams, MD

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G78386 BALTIMORE CITY HEALTH DEPARTMENT G78386

# CERTIFICATE OF DEATH

17 ✓

TH NO. Registered No.

AME OF DECEASED (or Print) Miriam G. Kuhns

2. DATE OF DEATH Sept. 24 1949

LACE OF DEATH: altimore City, Maryland 2420 Rogers Ave.

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) 2420 Rogers Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Same
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 2420 Rogers Ave. 27-15

Length of stay in Baltimore: Yrs. Life. Mos. Days

| EX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | Married | 6th 2 nd. 1884 | 65 | 3 / 22 | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | None | Baltimore Md. | U.S.A. |

FATHER'S NAME: Myer Greenbaum

14. MOTHER'S MAIDEN NAME: Fannie Samuels

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | none | Alexander Kuhns | 2420 Rogers Ave. |

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, breast, left. — INTERVAL BETWEEN ONSET AND DEATH: 4 years.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Metastases, bone — 2 years.

DUE TO Carcinomatosis — 2 months.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10th Dec. 1945 | Mastectomy, Radical, left. carcinoma | YES ☐ NO ☒ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ~ 1947, *to* 24 Sept, 1949, *that I last saw the deceased alive on* 23 Sept, 1949, *and that death occurred at* 8:30 a. m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Isaac P. Hamburger for M. D. | 1207 Eutaw Place. | 24 Sept 1949 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-25-49 | Balto. Hebrew Cem | Bel Air RD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 25 1949 | [illegible] for William M. [illegible] | David Sandler & Son | 1927 Eastern Ave. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

STH NO.

1. NAME OF DECEASED (Type or Print): Lillian E Williams
2. DATE OF DEATH: Sept 24-1949

3. PLACE OF DEATH: Baltimore City, Maryland 33
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3306 Elm Ave
Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 3306 Elm Ave 12-06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Aug 1867
9. AGE (In years last birthday): 82 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Brinkley
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: James E Williams ADDRESS: 3008 Grantley Rd

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs.
DUE TO
(B) Arteriosclerotic vascular disease.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sep 23, 1949 *to* Sept 24, 1949 *that I last saw the deceased alive on* Sept 23, 1949, *and that death occurred at* 3 40 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm N. McTaul Jr. M. D.
23B. ADDRESS: 1800 N. Charles St
23C. DATE SIGNED: 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: Sept 26-49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Mem Pk
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 25 1949
REGISTRAR'S SIGNATURE: Number from Williams, Mrs
25. FUNERAL DIRECTOR: Grant H. Seitz ADDRESS: 814 N. 36th St.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331 G78388 Registered No.

STH NO.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) Cora Lee | 2. DATE OF DEATH 9-22-49 |
| PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore |
| Length of stay in Baltimore 20 yrs. (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location) 1026 N. Central Ave. 10 01 |
| 5. SEX F | 6. COLOR OR RACE Negro |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Aug. 2, 1885 |
| 9. AGE (In years last birthday) 64 | If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) N. C. | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Dudley Crowell | 14. MOTHER'S MAIDEN NAME Henrietta Tillery |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
| 17. INFORMANT Records: | ADDRESS Baltimore City Hospitals 4940 Eastern Ave. |

## 18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable Cerebral Accident.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Obstructive Jaundice due To Common Duct Stone
Broncho Pneumonia.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION 9-19-49 | 19B. MAJOR FINDINGS OF OPERATION Common Duct Stone | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 9-1, 1949, *to* 9-22, 1949, *that I last saw the deceased alive on* 9-22, 1949 *and that death occurred at* 9:00 A.M., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE R. S. Rogers M. D. | 23B. ADDRESS Baltimore City Hospitals | 23C. DATE SIGNED 9-23-1949 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept. 24-49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem | 24D. LOCATION (City, town, or county) (State) Brooklyn Md |
| DATE RECEIVED BY LOCAL REGISTRAR 9/25/49 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR Elroy O. Wilson | ADDRESS 1108 Brantley Ave |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Mame Shroyer NOBLE

2. DATE OF DEATH 9-24-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Westminster
D. STREET ADDRESS (If rural, give location) 93 W. GREEN ST WESTMINSTR Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | MARRIED | 6/15/1891 | 58 | 3 | 9 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Taylors Inland. | MD. |

13. FATHER'S NAME RUFUS F. NOBLE

14. MOTHER'S MAIDEN NAME KATE SEWELL

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | MR WILLAM REESE. | WESTMINSTER MD |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | pulmonary thrombosis from C. A. accident | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arterio sclerosis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| none | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-21, 19 49, *to* 9-24, 19 49, *that I last saw the deceased alive on* 9-24, 19 49, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Harding M. D. | Community Hosp | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9/27/49 | WESTMINSTER. CEM | WESTMINSTER M-D |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Lurline Williams, M.D. | F A SHARRER & SON | WESTMINSTER M.D. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

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G78330

Registered No.

STH NO.

NAME OF DECEASED (Type or Print) George Olszewski (OLSMAN)

2. DATE OF DEATH Sept. 23, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 716 S. Dean St. 26-09

Length of stay in Baltimore 43 Yrs. Mos. Days

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 4/23/1891
9. AGE (In years last birthday) 58 — If Under 1 Year: Months 5, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Copper Smelting and Refining
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Olszewski
14. MOTHER'S MAIDEN NAME Louise ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Chester Olszewski ADDRESS Same.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Gastro-Intestinal Hemorrhage | 12 hrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Carcinoma of Oesophagus | 9 mos. |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Dipsomania Intoxication. | 3 wks. |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4:30 PM Sept 23, 1949 *to* 2:30 PM Sept 23 1949 *that I last saw the deceased alive on* Sept 23, 1949, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature]
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED Sept 23 '49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE 9-26-49.
24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem
24D. LOCATION (City, town, or county) (State) Dundalk Ave.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949
REGISTRAR'S SIGNATURE [signature] Clifton Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Charles S. Zeiler 901 S. Conkling

VS 150

46a

8391 ✓ 4 1b G78391

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

STH NO.

NAME OF DECEASED (Type or Print): Nettie Kraft

2. DATE OF DEATH: 9/24/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lorat Balto. Gen. Hosp

Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1933 W. Franklin Street 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | M | May 16, 1895 | 54 | 4 | 8 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Baltimore Co. Maryland | |

13. FATHER'S NAME: Edward Abaji Stocksdale

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | George H. Kraft | 1933 W. Franklin St. |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Obsumative Heart Disease | ? |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) Nephrosclerosis | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/19, 1949, *to* 9/24, 1949 *that I last saw the deceased alive on* 9/24, 1949, *and that death occurred at* 2:55 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Katherine V. Simms M. D. | Lorat Balto. Gen. Hosp | 9/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 27, 1949 | Mt. Olivet | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Timothy for Williams, M.D. | William Cook, Inc. | 1217 St. Paul St. |

VS 150

131a

:392 G78.392

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Emma L. Tener

2. DATE OF DEATH: Sept. 23, 1949

PLACE OF DEATH: Baltimore City, Maryland — Baltimore, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2634 N. Charles Street

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2634 N. Charles Street 12-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Widowed | March 14, 1863 | 86 | 6 / 9 | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| -- | | Pennsylvania | |

13. FATHER'S NAME: Charles Gardner

14. MOTHER'S MAIDEN NAME: Mary M. Bieler

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Miss Ida B. Gardner | 2634 N. Charles St. |

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

(B) Arteriosclerotic Cardiovascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 21, 1949 *to* Sept 23, 1949, *that I last saw the deceased alive on* Sept 23 1949 *and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Samuel D. Wolfe M.D. | 1331 E. North Ave | 9.25.49. |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| cremation | 9/26/49 | Green Mount Crematory | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., | 1217 St. Paul Street |

VS 150

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978393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 978393

BTH NO. BC. 49-18823

| | |
|---|---|
| NAME OF DECEASED (Type or Print) Baby Girl BATES | 2. DATE OF DEATH September 4, 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson 4 |
| Length of stay in Baltimore Yrs. 1 Mos. Days | D. STREET ADDRESS (If rural, give location) 24 Linden Terrace |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | S | September 3, 1949 | | — | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Newborn | — | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James P. BATES, Jr. | Margaret Dale HINSHAW |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mother | 24 Linden Terrace Towson 4, Md. |

## CAUSE OF DEATH

18.

I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B) Late abortion — 1 day

DUE TO

(C)

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 3, 1949, *to* Sept. 4, 1949, *that I last saw the deceased alive on* Sept 4, 1949, *and that death occurred at* 9:40 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert R. Millan M. D. | Union Memorial Hospital Baltimore 18, Md. | Sept 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | | |

VS 150 Body disposed of by Hospital

159

78394
S-93305

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78394

BTH NO.

NAME OF DECEASED (Type or Print): Rosa Brock

2. DATE OF DEATH: 9-22-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hospitals

Length of stay in Baltimore: 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 624 E. 31st Street. 9-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | Mar. 19, 1861 | 88 | 6 | 3 | | |

9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
9B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Mercer Bevans (D)
14. MOTHER'S MAIDEN NAME: Caroline Garner (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS EASTERN AVE. ADDRESS 4940

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerotic Heart Disease | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4-26, 1945 *to* 9-22, 1949, *that I last saw the deceased alive on* 9-22, 1949, *and that death occurred at* 10:45 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Sept 24, 49
24C. NAME OF CEMETERY OR CREMATORY: Mt Zion M.E.
24D. LOCATION (City, town, or county) (State): Bel Air Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: L. Heckmann & Son ADDRESS: 6067 Harford Rd.

VS 150

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78395

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

G78395

Registered No.

TH NO.

NAME OF DECEASED (Type or Print) Sarah Pecker

2. DATE OF DEATH 9/24/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

Length of stay in Baltimore 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-47
D. STREET ADDRESS (If rural, give location) 2322 Ashburton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Divorced | 1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Yehuda Kah
14. MOTHER'S MAIDEN NAME Rebecca Snyder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (No or unknown)
16. SOCIAL SECURITY NO.
17. INFORMANT Lucas Gottlieb ADDRESS 2322 Ashburton

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebro-Vascular Accident | 10 days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Hypertensive Heart Disease, Hypertensive Cerebro-Vascular Disease | |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 17 1949 to Sept 24, 1949, *that I last saw the deceased alive on* Sept 24, 1949, *and that death occurred at* 7:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Leon E. Lassel M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 9-28-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eastern Ave

VS 150

937

78596

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 34

78596 Registered No.

TH NO.

NAME OF DECEASED (Type or Print): Michael Gillooly

2. DATE OF DEATH: Sept 23 '49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 404 E. Chase St

Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 404 E. Chase St. 10 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 10, 1881 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Conductor | Penna Railroad | | |

13. FATHER'S NAME: Gillooly

14. MOTHER'S MAIDEN NAME: Gannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 717-07-8138

17. INFORMANT: Mrs Florence Gillooly ADDRESS: 404 E. Chas

## 18. CAUSE OF DEATH

I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis with — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO Cerebral Degeneration

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B)

DUE TO

(C)

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 1948, *to* Sept. 23, 1949, *that I last saw the deceased alive on* Sept. 22, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M. D. | 501 Sheridan Ave. | Sept. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 26 '49 | Loudon Park | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | Harry H. Wiltze | 414 Edmondson Ave |

VS 150

97

G78397

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78397

STH NO.

NAME OF DECEASED (Type or Print) Louisa Pace

2. DATE OF DEATH 9/25/49

PLACE OF DEATH: Baltimore City, Maryland 1314 Division St

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

Length of stay in Baltimore 30 yr Yrs. Mos. Days

3. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto md
d. STREET ADDRESS (If rural, give location) 1300 Division St. 17-0 W

| 4. SEX | 5. COLOR or RACE | 6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 7. DATE OF BIRTH | 8. AGE (If under 1 year, last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | Colored | Married | 1902 | 47 46 | — | — | — | |

| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 9B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | None | Virginia | U. S. A. |

10. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Wilbert Pace ADDRESS 1300 Division St.

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Chronic Congestive Heart Failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 9-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/29/49

24C. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park

24D. LOCATION (City, town, or county) (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Metropolitan Funeral Homes Inc ADDRESS 93E 9 L. N. Howard St

VS 151

78398

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9 0 1 L

Registered No. G78398

BIRTH NO.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | JOHN ANDERSON | N-804.2 | 2. DATE OF DEATH: September 23, 1949 |

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

Length of stay in Baltimore: 2 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 437 E. 20th Street 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Jan. 1, 1897 | 52 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Window Cleaner | Window Cleaning | Sweden | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Florence H. Anderson | 437 E. 20th St. |

## 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture, skull — INTERVAL BETWEEN ONSET AND DEATH: 1

DUE TO

(B) Subarachnoid hemorrhage
Fracture, femur left

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Building | 922 N. Charles Street 11-2 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| September 23, 1949 12:30P.m. | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | Fell while washing windows |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER ☒ / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| H. J. O'Mealey M.D. | | 9-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 9/26/49 | Green Mount Crematory | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | WM. J. TICHNER & SONS | Balto., Md. |

VS 151

186a

78399

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 97 · Registered No. 78399

BIRTH NO.

NAME OF DECEASED (Type or Print): AMELIA EISENHARDT N-965

2. DATE OF DEATH: September 23, 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2828 Raynor Avenue 16-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | widow | Jan. 10, 1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Philip Eck

14. MOTHER'S MAIDEN NAME: Bertha Wallmer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: no

17. INFORMANT: Mrs. Louise E. Barnes
ADDRESS: 1611 LockwoodRd

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carbon Monoxide Poisoning | |
| | DUE TO (B) | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2828 Raynor Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 23, 1949 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Head in oven--on but unlit

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: W. J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR

23C. DATE SIGNED: 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9/27/49

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, Md

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 151

163H

78400

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078400

TH NO.

NAME OF DECEASED (Type or Print): MARTHA HELENA NELSON

2. DATE OF DEATH: 25 SEPT 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5618 LOTHIAN ROAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 5618 LOTHIAN ROAD 37-48

Length of stay in Baltimore: 1 Yrs. Mos. Days

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | WIDOWED | AUGUST 28, 1868 | 81 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | — | SLATER, IOWA. | U.S.A. |

13. FATHER'S NAME: HEMMING ROMFA

14. MOTHER'S MAIDEN NAME: MARTHA H. (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) —
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: MRS. M.T. BRANDBERG ADDRESS: 5618 LOTHIAN ROAD

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arteriosclerotic Cardiovascular Disease | yrs? |
| DUE TO (B) | Senility. | years |
| DUE TO (C) | Chronic Myocarditis. | years |

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | | |

22. *I hereby certify that I attended the deceased from* November 1948, to 25 Sept., 1949, *that I last saw the deceased alive on* 25 Sept, 1949, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph E. Muse Jr M. D. | 5 West 29th St. Balto. | 25 Sept 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 30 SEPT. 1949 | MT. WASHINGTON CEM. | KANSAS CITY, MO. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Hunter for Williams, M.D. | Walter Burke Bradley | Dundalk |

VS 150

93D

78401 CERTIFICATE CORRECTED 10-25-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 G78401 Registered No.

TH NO.

AME OF DECEASED (or Print) Samuel Johnson

2. DATE OF DEATH Sept. 23, 1949

LACE OF DEATH: altimore City, Maryland

ULL NAME OF PITAL OR TITUTION (If not in hospital or institution, give street address or location) University Hospital.

ength of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 609 Dolphin St

| EX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Male | Negro. | Married | Sept. 23, 1894 | 55 | | |

| USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Maryland | U.S.A. |

FATHER'S NAME Robert Johnson

14 MOTHER'S MAIDEN NAME Alice Harriston

| WAS DECEASED EVER IN U. S. ARMED FORCES? (no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Henrietta Johnson | 609 Dolphin St |

## CAUSE OF DEATH

18.

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

(B) Cerebral hemorrhage - left. — 11 days.

DUE TO

(C) Hypertensive Cardio-vascular disease ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| NONE | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-6 1949, *to* 9-23, 1949, *that I last saw the deceased alive on* 9-23, 1949, *and that death occurred at* 11:50 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Patterson Finch M. D. | University Hospital | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-27-49 | Christian Mem. Pk | Baltimore Co Md |

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D.

AS FUNERAL DIRECTOR Mrs. Frances G. Hensley-Bidder — ADDRESS 5785 W

VS 150

93D

G78402

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78402

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AMALIE (Mollie) Dienhart

2. DATE OF DEATH: Sept. 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

Length of stay in Baltimore: 6 Yrs. 7 Mos. 16 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1403 Poplar Grove St

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Sept. 20. 1882

9. AGE (In years last birthday): 67
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress

10B. KIND OF BUSINESS OR INDUSTRY: B.V.D. Corporation

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julius J. DIENHART

14. MOTHER'S MAIDEN NAME: AUGUSTA EHOFF

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): (No, or unknown)

16. SOCIAL SECURITY NO.: 213-10-6299

17. INFORMANT: GRETCHEN DIENHART ADDRESS: 1403 Poplar Grove St.

## CAUSE OF DEATH

18.

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial decompensation c
DUE TO renal failure
(B) Pneumonia c pulm. infarction
DUE TO Atherosclerotic heart disease
(C)

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 19, 1949, *to* Sept. 23, 1949, *that I last saw the deceased alive on* Sept. 23, 1949, *and that death occurred at* 12:05 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Fred L. McClintock M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 9/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 9-26-1949

24C. NAME OF CEMETERY OR CREMATORY: Western

24D. LOCATION (City, town, or county) (State): BALTIMORE. MD

DATE RECEIVED BY LOCAL REGISTRAR: FEB 26 1949

REGISTRAR'S SIGNATURE: Tunstall for Williams, M.D.

25. FUNERAL DIRECTOR: G. HOWARD STRONG ADDRESS: 3207 W. NORTH AVE.

VS 150

93D

G78403 CERTIFICATE CORRECTED 11-7-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

561

G78403 Registered No.

STH NO.

NAME OF DECEASED (Type or Print) Mary Elizabeth Hosey

2. DATE OF DEATH 9/23/49

PLACE OF DEATH: Baltimore City, Maryland 1100 Mount St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1100-N. Mount St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 17. Maryland
D. STREET ADDRESS (If rural, give location) 16-03

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | Col. | Widow | April 22, 1893 | 56 | | |

10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME W Keatley Reed

14. MOTHER'S MAIDEN NAME Rachael Thisley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, yes or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary E. Hosey ADDRESS 1100-N. Mount St

## CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 29, 1949, to Sept 23, 1949, *that I last saw the deceased alive on* Sept 22, 1949, *and that death occurred at* 9.31 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. H. Patterman M. D.

23B. ADDRESS 2324 Reisterstown Rd

23C. DATE SIGNED 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/27/49

24C. NAME OF CEMETERY OR CREMATORY St. Peters Cem

24D. LOCATION (City, town, or county) (State) Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Metropolitan Funeral Home Inc.

ADDRESS 46F 9-27 N. Mount St

VS 150

G78404

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.H-00993 **CERTIFICATE OF DEATH** E81.0 Registered No. G78404

1. NAME OF DECEASED (Type or Print) JAMES LEE WINGATE N-81.4

2. DATE OF DEATH September 22, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp.

Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 746 E. Fort Avenue 7-4-52

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: 5/19/1944
9. AGE (In years last birthday): 5 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Z. Wingate
14. MOTHER'S MAIDEN NAME: Nettie V. Hamilton Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family - Same ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Chest
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 700 block of Harvey Street 24/2
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY September 22, 1949 9.30 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Pedestrian struck by truck

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23a. SIGNATURE Earl L. Koyen M.D.
23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23c. DATE SIGNED Sept. 22, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE 9/26/49
24c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24d. LOCATION (City, town, or county) (State): Brooklyn, Maryland

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR James L. McCauley ADDRESS - 130 E. Fort Ave.

VS 151

170c

78405

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50 G78405 Registered No.

BTH NO.

| | |
|---|---|
| NAME OF DECEASED (Type or Print) CHARLES A. MESEKE | 2. DATE OF DEATH 9/23/49 |
| PLACE OF DEATH: Baltimore City, Maryland 3206 Chesterfield Ave | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Md. b. COUNTY |
| FULL NAME OF OSPITAL OR STITUTION (If not in hospital or institution, give street address or location) | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore |
| Length of stay in Baltimore Yrs. Mos. Days | d. STREET ADDRESS (If rural, give location) 3206 Chesterfield Ave. 26-C |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | W | 5/19/1875 | 74 | | |

| 10a. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Emp. Of W.M. R.R. | | Ohio | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Meseke | Louise Scheeler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Family - Same |

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Oesophagus — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.

DUE TO

(B) Acute heart failure (Regurgitation) — 3 hrs.

DUE TO

(C) Arteriosclerotic Cardio Vascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Apr 7, 1949, *to* Sept. 23, 1949 *that I last saw the deceased alive on* Sept 23 1949, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Carlton E. Keefer M. D. | 10 W. Madison St. | 9.24.49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 9/26/49 | Cedar Hill | Brooklyn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Lexington Williams, M.D. | Jesse L. McCully | 130 E. Fort Ave. |

VS 150

46a

A POST PARTUAL NEONATAL DEATH ✓ X THIS Child lived 3 MINUTES

G78406

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78406

BTH NO B.C.49-20888

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | BABY GIRL PERRY |
| 2. DATE OF DEATH | 25 Sep 49 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | MERCY HOSPITAL |
| Length of stay in Baltimore | NEONATAL DEATH - 3-5 MINUTES (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | MD |
| B. COUNTY | BALTO |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Balto |
| D. STREET ADDRESS (If rural, give location) | 2923 York Way |
| 5. SEX | F |
| 6. COLOR OR RACE | W |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | |
| 8. DATE OF BIRTH | 25 Sep 49 |
| 9. AGE (In years last birthday) | — |
| If Under 1 Year: Months / Days | — / — |
| If Under 24 Hours: Hours / Min. | — / 3 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | — |
| 10B. KIND OF BUSINESS OR INDUSTRY | — |
| 11. BIRTHPLACE (State or foreign country) | MD. |
| 12. CITIZEN OF WHAT COUNTRY? | USA |
| 13. FATHER'S NAME | Charles Owen Perry |
| 14. MOTHER'S MAIDEN NAME | Lucille Nelson |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | MOTHER |
| ADDRESS | SAME |

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) PLACENTAL SEPARATION | 2 weeks |
| DUE TO | | |
| ANTECEDENT CAUSES | (B) PLACENTAL INFARCTION | 2 weeks |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | PREMATURITY | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
| None | — | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| | | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
| m. | | |

22. *I hereby certify that I attended the deceased from* 25 Sep, 1949, *to* 25 Sep, 1949, *that I last saw the deceased alive on* 25 Sep, 1949, *and that death occurred at* 935 A m, *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| John A Ferris M. D. | Mercy Hosp. | 25 Sep 49 |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | Sept. 26, 1949 | Moreland Park Cem. | Baltimore, Md. |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| SEP 26 1949 | Huntington Williams, M.D. | Roland L. Fisher | 2112 Dundalk Ave. |

VS 150

160c

G78407 X ✓ 434 3. G78407

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

NAME OF DECEASED (Type or Print) Lyle F De Vilbiss Lyle F. DeVilbiss

2. DATE OF DEATH 9/24/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Larchmont
D. STREET ADDRESS (If rural, give location): 2302 Birch Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 7, 1906 | 43 yrs | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ectly to Chief Eng.
10B. KIND OF BUSINESS OR INDUSTRY: B & O RR
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles A. DeVilbiss
14. MOTHER'S MAIDEN NAME: Kathryn Fowler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO. 705-05-0079
17. INFORMANT: Mrs. Christine K. DeVilbiss, ADDRESS 2302 Birch Drive, Larchmont

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Uremia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Chronic Glomerular Nephritis

DUE TO

(C) Cardiac hypertrophy and hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22, 1949, *to* 9-24, 1949 *that I last saw the deceased alive on* 9-24, 1949, *and that death occurred at* 4:25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Katherine K. Kemp M. D.
23B. ADDRESS: West. Balto Gen. Hosp.
23C. DATE SIGNED: 9/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 27, 1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilkes Funeral
ADDRESS: 4510 Liberty Heights Ave.

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78408

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78408

BTH NO. Registered No.

NAME OF DECEASED (Type or Print): Mrs. Mamie Martha Moreland

2. DATE OF DEATH: 9-24-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4044 Alameda Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Married | 10-16-78 | 70 71 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wilmington, Del.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Allen

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS:

## CAUSE OF DEATH

15. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

(B) Hypertension & Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-24-49, 19__, *to* 9-24-49, 19__, *that I last saw the deceased alive on* 9-24-49 19__, *and that death occurred at* 7:25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. C. Decker M. D.

23B. ADDRESS: Women's Hospital

23C. DATE SIGNED: 9-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Sept 26 1949

24C. NAME OF CEMETERY OR CREMATORY: Glen Haven

24D. LOCATION (City, town, or county) (State): Glenburnie Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Ulbrich Funeral Home

ADDRESS: 2001 Pulaski H

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78409

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

G78409

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Virginia Chelton Woolford

2. DATE OF DEATH: Sept 22-1949

PLACE OF DEATH: Baltimore City, Maryland 3635 Mt Elderry R

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3035 Mt Elderry St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto 1632 Raleworth Rd
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 1632 Ralworth Rd

Length of stay in Baltimore: Life. (Yrs. / Mos. / Days)

3. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 84. 1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Augustus Chelton
14. MOTHER'S MAIDEN NAME: — Haines.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs John Mutch ADDRESS: 1212 N Ellwood Ave

## CAUSE OF DEATH

18.

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — ONSET AND DEATH: 1 Day

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Arteriosclerosis. — ONSET AND DEATH: 4 years appx

DUE TO

(C) Hypertension — ONSET AND DEATH: 4 years appx

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 Dec, 19 49, *to* 22 Sept, 19 49, *that I last saw the deceased alive on* 21 Sept, 19 49, *and that death occurred at* 3.30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harold Schwartzman M. D.
23B. ADDRESS: 1513 N. Milton Ave
23C. DATE SIGNED: 24 Sept 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept 26/1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Ulrich Funeral Home ADDRESS: 2005 Eutaw St

VS 150

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G78410

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51 Registered No. G78410

TH NO.

NAME OF DECEASED (Type or Print) Adolf Woernle

2 DATE OF DEATH 24 Sept

PLACE OF DEATH Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B COUNTY Baltimore

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hospital

C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fullerton, Md.

Length of stay in Baltimore 43 Yrs. Mos. Days

D STREET ADDRESS (If rural, give location) 7932 Belair Rd.

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| m | W | married | Oct. 22nd, 1873 | 75 | 11 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Printer | Owner | Germany | USA |

13. FATHER'S NAME Wilhelm Woernle

14 MOTHER'S MAIDEN NAME Elizabeth Buck

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Aldolf Woernle, Sr. | 7932 Belair Rd. |

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Carcinoma Stomach.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 25 July | Carcinom Stom. | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 21 July, 1949 *to* 24 Sept, 19 49, *that I last saw the deceased alive on* 24 Sept, 19 49 *and that death occurred at* 2 ½ Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Richard D. Loomer M. D. | Univ. Hospital | 24 Sept 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 9/27/49 | Parkwood | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | Loeschin Funeral Home | 7401 Belair Rd. |

VS 150

46B

G78:11

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78:11

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Franklin E. Becket

2. DATE OF DEATH: 24 Sept. 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital (DOA)

Length of stay in Baltimore: 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 510 Tunbridge Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 7-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tool & Dye Maker | Machine Shop | York Pa. | |

13. FATHER'S NAME: Ralph Becker

14. MOTHER'S MAIDEN NAME: Sarah Jane Snowden

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. — | 215-07-2010 | Mrs Mary A Becker | 510 Tunbridge |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

(B) Diabetes Mellitus — 15 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D. | | 24 Sept. 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 27th 1949 | Oakwood | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Hunter Williams, MD | Peters & Son | 2244 Chas |

VS 151

61

78412 ✓ 331 G78412

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dora D. Walter

2. DATE OF DEATH: Sept. 22, 1949

PLACE OF DEATH: Baltimore City, Maryland 1525 N.Chapel St.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1525 N.Chapel St.

Length of stay in Baltimore: Yrs. 8 Mos. 0 Days 7

| SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | Oct. 9, 1888 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Hooske
14. MOTHER'S MAIDEN NAME: Kumnigunda Dekate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Frederick Walter ADDRESS: 1525 Chapel St.

## 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 7 1/2 yrs |
| DUE TO (B) | Essential Hypertension | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchopneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan. 1946 19__, *to* Sept 22, 1949 *that I last saw the deceased alive on* Sept. 21, 1949 *and that death occurred at* 2 P? *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Krueger M. D. | 1402 E. Lanvale St. | Sept. 24th 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/26/49 | Parkwood | Taylor Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Thurlington Williams, M.D. | Clarence F. Hoffmann | 1639 Broadway |

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83a

8413

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 176

G78413 Registered No.

BTH NO. B.C. H-38771

NAME OF DECEASED (Type or Print) Russell E. Bitz

2. DATE OF DEATH 9/25/49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1431 Winston Ave

Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27 39
D. STREET ADDRESS (If rural, give location) 1431 Winston Ave

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Single | 12/23/45 | 3 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Franklin W. Bitz Jr.
14. MOTHER'S MAIDEN NAME Margaret Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Franklin W. Bitz Jr. ADDRESS 1431 Ave Winston

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Seminoma right testicle with metastases to liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-25-49 | Seminoma (Teratoma) right testicle | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6-25- , 1949 to 9-25 , 1949 *that I last saw the deceased alive on* 9-24 , 1949 *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melton C. Carey M. D. | 2117 Belair Rd | 9-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/27/49 | St Peter's Cem. | Moreland Ave Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams M.D. | John J. Cowan & Son | 510 Gilmor St. |

51C

To Be Approved By Chief Med. Examiner ✓ K

78414 — E 900.0 — G78414

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | Daisy Mayes. N-8 14.0 |
| 2. DATE OF DEATH | 24 Sept 49 |
| PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | Baltimore |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Maryland Gen'l Hosp. |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Fullerton, Md. |
| Length of stay in Baltimore — Yrs. / Mos. / Days | |
| D. STREET ADDRESS (If rural, give location) | 7850 Belair Rd. |
| 5. SEX | Female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widowed |
| 8. DATE OF BIRTH | April 25th, 1875 |
| 9. AGE (In years last birthday) | 74 |
| If Under 1 Year: Months / Days | 4 / 29 |
| If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Unknown |
| 12. CITIZEN OF WHAT COUNTRY? | USA |
| 13. FATHER'S NAME | Unknown |
| 14. MOTHER'S MAIDEN NAME | Unknown |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | Mr. Charles Mayes |
| ADDRESS | |

## CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CERTIFICATION APPROVED BY
Fred W. Kammer per
B B Parker M.D.
CHIEF OR ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture - Rt Humerus

INTERVAL BETWEEN ONSET AND DEATH

| | |
|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION |
| 20. AUTOPSY? | YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | Accident. |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | Home |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | 7850 Belair Rd. 53-00 |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 9 8 48. m. |
| 21E. INJURY OCCURRED | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ |
| 21F. HOW DID INJURY OCCUR? | Pt Fell while going down steps |

22. *I hereby certify that I attended the deceased from* 12 Sept, 1949, *to* 24 Sept, 1949, *that I last saw the deceased alive on* 24 Sept, 1949, *and that death occurred at* 5:25 m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Frank G Cressang M. D. | |
| 23B. ADDRESS | Md. Gen'l Hosp. | |
| 23C. DATE SIGNED | 9/24/49 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | burial | |
| 24B. DATE | 9/27/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Salem Methodist | |
| 24D. LOCATION (City, town, or county) (State) | Baltimore County | |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 26 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, M.D. | |
| 25. FUNERAL DIRECTOR | Lasahn Funeral Home | |
| ADDRESS | 7401 Belair Rd. | |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREDERICK A. RUST

2. DATE OF DEATH: 9-25-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL of BALTIMORE

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-21
D. STREET ADDRESS (If rural, give location): 3117 Heaver Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hours: Hours | If Under 24 Hours: Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | WIDOWER | June 6-1889 | 60 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hatter
10B. KIND OF BUSINESS OR INDUSTRY: Mens Hat Co.
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ✓
14. MOTHER'S MAIDEN NAME: ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Harold Sager - 3117 Heaver ADDRESS

## CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL ANEURYSM
DUE TO
(B)

**ANTECEDENT CAUSES**
**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.
DUE TO
(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17, 1949 *to* 9-25, 1949 *that I last saw the deceased alive on* 9-25, 1949, *and that death occurred at* 7⁰⁵ a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arnold V. Michael M. D.
23B. ADDRESS: Sinai Hospital / Balto.
23C. DATE SIGNED: 9-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-22-49
24C. NAME OF CEMETERY OR CREMATORY: Trinity Cem.
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck - 5305 ADDRESS Harford Rd.

VS 150

96

3416 — G78416

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | Malgozota | Wasiewski | 2. DATE OF DEATH: Sept. 23-1949 |

3. PLACE OF DEATH: Baltimore City, Maryland — Balto. City

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1717 Gough St

Length of stay in Baltimore: 55 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 1717 Gough St. 2-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Nov. 1859 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| Alexander Szymanski | Maryanna Krotarski |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, or unknown, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No / No | — | Lena Jagodzinski | 1717 Gough St |

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | 10 yrs |
| DUE TO (B) | Senile Arteriosclerosis | 10 yrs |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 20 *20* 1949, *to* Sept 23, 1949, *that I last saw the deceased alive on* Sept 23 *20* 1949, *and that death occurred at* 4:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton L. Solomon M. D. | 124 S. Bway | 9/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 27-1949 | Holy Rosary | Balto - Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | Wm. S. Fialkowski | 2007 Eastern Ave |

VS 150

93D

3417 G78417

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
1950 Registered No.

BIRTH NO.

NAME OF DECEASED (Type or Print): FRED IVAN MORRIS

2. DATE OF DEATH: Sept. 25, 1949

PLACE OF DEATH: Baltimore City, Maryland Marine Hospital

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.

Length of stay in Baltimore: 76 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Warsaw
D. STREET ADDRESS (If rural, give location): Route 1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | 3/23/80 | 69 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | | Va. | USA |

13. FATHER'S NAME: Fax Morris

14. MOTHER'S MAIDEN NAME: Virginia Ramsey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | ? | Records- US Marine Hospital, Balto, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Squamous cell carcinoma of skin of right neck and ear with metastases to regional lymph nodes.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pneumonia right and left lower lobes, terminal. Edema of brain. Arteriosclerosis general. ) Unknown

INTERVAL BETWEEN ONSET AND DEATH: ? 10 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | Arteriosclerosis of kidney) | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 11, 1949 *to* Sept. 25, 1949, *that I last saw the deceased alive on* Sept. 25, 1949 *and that death occurred at* 7:05 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 9/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Woodlawn Grove Cemetery | Maryland Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | John O. Mitchell Sons | 1911 Eutaw Place |

VS 150

53

G78418

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78418

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | PRUDENCE ANN CHANEY (nee Cavey) |
| 2. DATE OF DEATH | Sept. 24, 1949 |
| 3. PLACE OF DEATH: | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 7200 Shadow Lawn Ave. |
| Length of stay in Baltimore — Yrs. / Mos. / Days | |
| D. STREET ADDRESS (If rural, give location) | 717 Linnard St. |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widow |
| 8. DATE OF BIRTH | Sept. 2, 1862 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min. | 87 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | Home |
| 11. BIRTHPLACE (State or foreign country) | Howard Co., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | William Cavey |
| 14. MOTHER'S MAIDEN NAME | Mary C. Frost |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT / ADDRESS | Mrs. Charles Miller 7200 Shadow Lawn Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Sept. 3, 1949, *to* Sept. 24, 1949, *that I last saw the deceased alive on* Sept. 24, 1949, *and that death occurred at* 9:10 P m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| Nathan Janney M. D. | 7101 Harford Rd. | 9/26/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial | 9/28/49 | Western Cem. |
| 24D. LOCATION (City, town, or county) (State) | | |
| Balto., Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
| SEP 26 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

VS 150

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8419

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31

Registered No. G78419

BIRTH NO.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | WILLIAM J. HEWITT | 2. DATE OF DEATH | Sept. 23, 1949 |
| 3. PLACE OF DEATH: Baltimore City, Maryland | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 4416 Parkmont Ave. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| Length of stay in Baltimore — Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) | 4416 Parkmont Ave. 26-01 |
| 5. SEX | male | 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married | 8. DATE OF BIRTH | Oct. 4, 1872 |
| 9. AGE (In years last birthday) | 76 yrs. | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Machinist (rtd) | 10B. KIND OF BUSINESS OR INDUSTRY | Railroad |
| 11. BIRTHPLACE (State or foreign country) | King of Persia, Pa. | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Ephrim Hewitt | 14. MOTHER'S MAIDEN NAME | Mary Jane Naye |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no | 16. SOCIAL SECURITY NO. | 705-10-2091 |
| 17. INFORMANT | Mrs. Nellie G. Hewitt | ADDRESS | 4416 Parkmont Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arterio-Sclerosis | 2 yrs |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Cerebral hemorrhage | 3 weeks |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Hypostatic pneumonia | 3 days |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Sept 2, 1949, *to* Sept 23, 1949, *that I last saw the deceased alive on* Sept 23, 1949, *and that death occurred at* 2 45 *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Edward Hanson M. D. | 23B. ADDRESS 1W. Preston |
| 23C. DATE SIGNED | 9/26/49 | |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 24B. DATE | 9/26/49 |
| 24C. NAME OF CEMETERY OR CREMATORY | Balto. National Cem. | 24D. LOCATION (City, town, or county) (State) | Balto., Md. |
| DATE RECEIVED BY LOCAL REGISTRAR | SEP 26 1949 | REGISTRAR'S SIGNATURE | Registrar Williams, M.D. |
| 25. FUNERAL DIRECTOR | WM. J. TICKNER & SONS | ADDRESS | Balto., Md. |

VS 150

83a

G78420

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78420

BIRTH NO.

NAME OF DECEASED (Type or Print) ANNA F. TATTERSALL

2. DATE OF DEATH 9-25-49

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN SQUARE HOSPITAL

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Bo Hq.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) UPERCO
D. STREET ADDRESS (If rural, give location) UPERCO Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | widowed | May 20, 1876 | 73 yrs. | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Pittson, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME - Kennedy
14. MOTHER'S MAIDEN NAME Bridget Tyge
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. S. PEDERSON ADDRESS Ferndale Rd. FERNDALE, Md

## 18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) PERITONITIS, GENERALIZED

DUE TO

(B) RUPTURED DIVERTICULUM

DUE TO

(C) STRANGULATED FEMORAL HERNIA RIGHT

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: QUESTIONABLE, ABOUT TWO weeks from this.

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-24, 1949 *to* 9-25, 1949, *that I last saw the deceased alive on* 9-25, 1949, *and that death occurred at* 8:55 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Oscar Blanch M.D.
23B. ADDRESS FRANKLIN SQ. HOSP.
23C. DATE SIGNED 9-25-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/28/49 | Cathedral Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150 Oscar B. Camp

122a

G78421

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-20995 **CERTIFICATE OF DEATH** 773.0 Registered No. G78421

1. NAME OF DECEASED (Type or Print): Baby Boy Maxwell

2. DATE OF DEATH: Sept. 24, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

3b. Length of stay in Baltimore: 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20
D. STREET ADDRESS (If rural, give location): 14 Yawmeter Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 21, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 2 | 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Oliver Maxwell
14. MOTHER'S MAIDEN NAME: Thore
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (No, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Joseph Maxwell
ADDRESS: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
~~DUE TO~~
(C) Sclero derma

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21-49, 1949, to 9-24-49, 1949, *that I last saw the deceased alive on* 9-24-49, 1949, *and that death occurred at* 10:35 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Vito L Coppa, M. D.
23b. ADDRESS: 1400 N. Caroline St. Baltimore 13, Md.
23c. DATE SIGNED: 9-24-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 26-1949
24c. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24d. LOCATION (City, town, or county) (State): Hammonds Hill Rd. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J Connelly
ADDRESS: Govd 21, Md.

VS 150

153

G78:22

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78:22

BIRTH NO.

1. NAME OF DECEASED (Type or Print): David Marion West

2. DATE OF DEATH: SEP 25 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lives Nelson
D. STREET ADDRESS (If rural, give location): R.D. Rt. 3 Salmas Del

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 10-29-43 | 5 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Marion J. West
14. MOTHER'S MAIDEN NAME: Clara Shockley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Increased intracranial pressure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Undetermined cause

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: Hydrocephalus - Ventriculostomy performed
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-9- 1949, *to* 9-25 1949, *that I last saw the deceased alive on* 9-25 1949, *and that death occurred at* 7 05 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Daniel J. Birmingham M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/28/49
24C. NAME OF CEMETERY OR CREMATORY: Nelson Cemetery
24D. LOCATION (City, town or county) (State): Wicomico County Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Tunstington Williams, M.D.
25. FUNERAL DIRECTOR: Holloway & Salisbury
ADDRESS: Md

VS 150

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78423

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78423

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) CHARLES OTTER | 2. DATE OF DEATH Sept. 23, 1949 |
| 3. PLACE OF DEATH: Baltimore City, Maryland 3111 E. Monument St. (If not in hospital or institution, give street address or location) FULL NAME OF HOSPITAL OR INSTITUTION | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3111 E. Monument St. |
| Length of stay in Baltimore life (Yrs. Mos. Days) | 7-01 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 5, 1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ier Supt. | United Fruit Co. | Baltimore, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| August Otter | Anna Figinger |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | 212-03-1637 | Mrs. Mary Davies Otter - 3111 E. Monument S |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

(B) Coronary Thrombosis — 4 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-15-49 19__, *to* 9/23/49 19__, *that I last saw the deceased alive on* 9/22/49 19__, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. H. Harriman MD M. D. | 1706 33rd St | 9/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/27/49 | Western Cemetery | Edmondson & Longwood, Balto. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 26 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 150

94a

G78424 G78424

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 174

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah J. Wickert
2. DATE OF DEATH: Sept 24 1949
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 858 W. 37th St.
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home
Length of stay in Baltimore: Yrs. 13 Mos. Days 7
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov 30 1887
9. AGE (In years last birthday): 61 If under 1 year: Months Days If under 24 hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William H. Stone
14. MOTHER'S MAIDEN NAME: Rachel Huff
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service): — —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: William L Wickert ADDRESS: 858 W. 37th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Uterus & Bladder — INTERVAL BETWEEN ONSET AND DEATH: 6 Month
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1949, to Sept. 23, 1949, *that I last saw the deceased alive on* Sept 23, 1949, *and that death occurred at* 3:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur G Davis M. D. | 23B. ADDRESS: 800 W 32nd St. | 23C. DATE SIGNED: 9-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 9/26/49 | 24C. NAME OF CEMETERY OR CREMATORY: Westminster | 24D. LOCATION (City, town, or county) (State): Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949 | REGISTRAR'S SIGNATURE: Carrington Williams, M.D. | 25. FUNERAL DIRECTOR: Paul E. Lehnert Jr. | ADDRESS: 3615-17 Christian Ave

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48 B

G78425 G78425

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C.49-20154 **CERTIFICATE OF DEATH** 45 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Sobolewski

2. DATE OF DEATH September 24 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital Belt. Road, Md

c. Length of stay in Baltimore ½ Hour (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21
D. STREET ADDRESS (If rural, give location) 935 Woodlawn Rd.

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH September 24 | 9. AGE (In years last birthday) ½ Hour | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. 30

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thaddeus Sobolewski

14. MOTHER'S MAIDEN NAME Margaret Reese

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Spina bifida — INTERVAL BETWEEN ONSET AND DEATH ½ HR.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 24, 1949, to Sept 24, 1949 *that I last saw the deceased alive on* Sept 24, 1949, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Mary E. Matthews M. D. | 23B. ADDRESS Mercy Hospital | 23C. DATE SIGNED Sept. 24 '49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 9-26-49 | 24C. NAME OF CEMETERY OR CREMATORY St. Peters | 24D. LOCATION (City, town, or county) (State) City

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wiedefeld & Son ADDRESS Green Mount Ave & 32nd St.

VS 150

157B

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G78:26 | 151 | Registered No. G78:26

NAME OF DECEASED (Type or Print): ARLENA (LEONARD) WELLS

2. DATE OF DEATH: 9/23/49

PLACE OF DEATH: Baltimore City, Maryland — 207 N. Fremont Av

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 207 N. Fremont Av — 4-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Single | ? 1874 | 75 ? | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | | Md | U.S.A. |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | None | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Carcinoma of Stomach | |
| DUE TO | | |
| (B) | With Metastasis, | 6 mos. |
| DUE TO | | |
| (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/7/49 *to* 9/23/49, *that I last saw the deceased alive on* 9/23/49, *and that death occurred at* 7:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Lacken M.D. | 600 N. Arlington Ave | 9/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/26/49 | Mt. Auburn | Balto Md. |

| FILED (Date) DEC 2 1949 DEPUTY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Hunter Jr. Williams, M.D. | Chas. H. Hoper | 5 N. Arlington Ave |

VS 150

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78427 ✓ 760 G78427

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. B.C.49-20819 Registered No.

1. NAME OF DECEASED (Type or Print): Paul Combs
2. DATE OF DEATH: Sept. 25, 1949
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 403 Bunsryan St. 76-05
3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
3b. Length of stay in Baltimore: Life (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Sept. 23, 1949 | | 0 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Newborn | NONE | Maryland | U.S. |

13. FATHER'S NAME: Allan Combs
14. MOTHER'S MAIDEN NAME: Irene Demetrican
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: ALLEN COMBS. ADDRESS: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subperiosteal (cranial) a
DUE TO Subarachnoid hemorrhage
(B) Birth trauma
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 24 1949, *to* Sept. 25 1949 *that I last saw the deceased alive on* Sept 25 1949, *and that death occurred at* 6 30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. F. Cox M.D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 9/26/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 9/26/49 | SACRED HEART | BALTO. CO. |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: KALLY & ZEILER ADDRESS: BALTO.

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G78428

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

57-0 G78428

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | Nicholas S. Mack |
| 2. DATE OF DEATH | Sept 23, 1949 |
| PLACE OF DEATH: Baltimore City, Maryland | Ward 4 |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Johns Hopkins Hospital |
| Length of stay in Baltimore | Yrs. Mos. Days |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | Balto |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Fort Howard |
| D. STREET ADDRESS (If rural, give location) | North Point Road. |
| 5. SEX | Male |
| 6. COLOR OR RACE | White |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | Single |
| 8. DATE OF BIRTH | 4-10-49 |
| 9. AGE (In years last birthday) | If Under 1 Year: Months / Days: J — If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Child |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Md. |
| 12. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 13. FATHER'S NAME | Michael Mack |
| 14. MOTHER'S MAIDEN NAME | Kathryn Hager |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | No |
| (If yes, give war or dates of service) | None |
| 16. SOCIAL SECURITY NO. | None |
| 17. INFORMANT ADDRESS | Michael Mack-North Point Rd. Ft. Howard, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningococcic meningitis

DUE TO

(B) Meningococcemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 9-23-, 1949, *to* 9-23-, 1949, *that I last saw the deceased alive on* 9-23, 1949, *and that death occurred at* 10:10 m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| William W. Canning, M. D. | Johns Hopkins Hospital | 9-23-49 |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | 9/26/1949 | Oak Lawn | Baltimore County Md. |

| | | |
|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
| SEP 26 1949 | Huntington Williams M.D. | Lilly & Zeiler Inc. 403 S. Wolfe St. Balto. |

VS 150

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G78429

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

63

G78429

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) JUAN ALLEGE

2. DATE OF DEATH Sept. 19, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

3c. Length of stay in Baltimore 44 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Va. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Norfolk
D. STREET ADDRESS (If rural, give location) 128 Talbot St.

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH 12/25/88

9. AGE (In years last birthday) 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AB seaman

10b. KIND OF BUSINESS OR INDUSTRY Seafarer

11. BIRTHPLACE (State or foreign country) Spain

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Manuel Allege

14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 019-16-6354

17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 6, 1949, *to* Sept. 19, 1949, *that I last saw the deceased alive on* Sept. 19, 1949, *and that death occurred at* 1.25P *m., from the causes and on the date stated above.*

23a. SIGNATURE John F Rooney M. D.

23b. ADDRESS US Marine Hospital, Balto, Md.

23c. DATE SIGNED 9/24/49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/26/49

24c. NAME OF CEMETERY OR CREMATORY Sacred Heart

24d. LOCATION (City, town, or county) (State) Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Tully & Zeiler ADDRESS 4038 Norfolk Ave

VS 150

477

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

5 3 3 5 Registered No. G78430

BIRTH NO. 30

1. NAME OF DECEASED (Type or Print) George P. Dressel

2. DATE OF DEATH Sept 25/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 3127 Marsco Ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 3127 Marsco Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year, last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | W. | divorced | July 29/880 | 69 | | 1 | 26 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George E. Dressel

14. MOTHER'S MAIDEN NAME Mary A. Hoffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Mrs. M. Montgomery ADDRESS 3127 Marsco Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Epilepsy

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Severe Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 21, 1949, *to* Sept 25, 1949 *that I last saw the deceased alive on* Sept 24 1949, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE L. B. Stevens M. D.

23B. ADDRESS 3400 Erdman Ave

23C. DATE SIGNED 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/28/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore

24D. LOCATION (City, town, or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington for Nathanson, M.D.

25. FUNERAL DIRECTOR Philip Herwig Sons

ADDRESS 2024 Orleans St

VS 150

each worksheet —

83a

978431

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

413 . G78431 Registered No.

1. NAME OF DECEASED (Type or Print): Hattie Holloway

2. DATE OF DEATH: Sept 23 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION: (If not in hospital or institution, give street address or location) 1403 N. Carolina St

c. Length of stay in Baltimore: 20 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1403 N. Carolina St

8-27

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | Feb 9 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Smithfield Va. | |

13. FATHER'S NAME: Levi Colens

14. MOTHER'S MAIDEN NAME: Ellen Colens

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Margella Cotton | Mitchell |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

DUE TO

(B) Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 18, 1949 *to* Sept 23, 1949, *that I last saw the deceased alive on* Sept 22, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. R. Adams M. D. | 1222 N. Caroline St | Sept 26 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Sept 27 49 | Mt | Smithfield Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Hattie Williams, M.D. | Mrs. Robert G. Ellis & Daughter | 937 1129 N. Carolina St. |

VS 150

978432

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 978132

1. NAME OF DECEASED (Type or Print) Ronald Earl Williams

2. DATE OF DEATH Sept. 24-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 412 N. Calhoun St.

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-07
D. STREET ADDRESS (If rural, give location) 412 N. Calhoun St.

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) Married

8. DATE OF BIRTH Feb. 14 1904

9. AGE (In years last birthday) 45 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk

10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Williams.

14. MOTHER'S MAIDEN NAME Eliza Pullet

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Isabelle Williams ADDRESS 412 N. Calhoun

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension Cardio-

DUE TO

(B) Vascular Renal Disease 6 mon.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1, 1949 *to* 9/24, 1949, *that I last saw the deceased alive on* 9/24, 1949, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE H. H. Lackey M. D.

23B. ADDRESS 600 Harlem Ave

23C. DATE SIGNED 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Sept. 27-1949

24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State) Arbutus, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Earl Gilmore ADDRESS 519 Mosher St.

VS 150

121a

G78433

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78433

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Phillip Stengler

2. DATE OF DEATH: Sept 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3015 Northway Drive

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3015 Northway Drive 27-05

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1/12/92

9. AGE (In years last birthday): 57 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor Bakery Dept.

10B. KIND OF BUSINESS OR INDUSTRY: Grocery Bus.

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Phillip Stengler

14. MOTHER'S MAIDEN NAME: Ida Koffern

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes

(If yes, give war or date of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Lola Stengler ADDRESS: Balto Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 to 9/25, 1949 *that I last saw the deceased alive on* 9/25, 1949 *and that death occurred at* 9 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Helen M. Bolley M. D.

23B. ADDRESS: 5703 Harford Rd

23C. DATE SIGNED: 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 9/29/49

24C. NAME OF CEMETERY OR CREMATORY: Balto. National

24D. LOCATION (City, town, or county) (State): Frederick Ave. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949

REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.

25. FUNERAL DIRECTOR: Mildred J. Blight, ADDRESS: 6009 Harford Rd

VS 150

94a

G78434

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51

G78434

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): MARY SALOME KORB

2. DATE OF DEATH: SEPT. 24, 1949.

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4212 SHERBROOK AVE.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MARYLAND B COUNTY: BALTIMORE CITY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
d. STREET ADDRESS (If rural, give location): 4212 SHERBROOK AVE 2F-01

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: MAY 7, 1869
9. AGE (In years last birthday): 80 YRS. (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOSHUA X. AMOS
14. MOTHER'S MAIDEN NAME: MARGARET LOVELL
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: AMOS A. KORB. ADDRESS: 4212 SHERBROOK AVE. 16.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Stomach | about 1 yr. |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| (B) | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | Generalized | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Arterio-Sclerosis | about 2 years |

19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February, 1948 *to* Sept 24, 1949 *that I last saw the deceased alive on* Sept 23, 1949, *and that death occurred at* 1:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Julius C. Bluck M. D. | 23B ADDRESS: 5356 Reisterstown Rd | 23C DATE SIGNED: 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: SEPT. 26, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: ST. MARYS CEMETERY | 24D LOCATION (City, town, or county) (State): HAMPDEN, BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25 FUNERAL DIRECTOR: LORING BYERS | ADDRESS: 5005 PARK HEIGHTS AVE

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46 B

78435

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78435

1. NAME OF DECEASED (Type or Print) WILLIAM HERBERT NEAL

2. DATE OF DEATH September 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1424 N. Mount Street 15-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | married | June 1, 1889 | 60 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none LABORER | ODD JOBS | Maryland | |

13. FATHER'S NAME: James Neal

14. MOTHER'S MAIDEN NAME: Georgianna Ester

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Violetta Neal | 1424 N. Mount St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic cardiovascular disease. | |
| | DUE TO | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* In quiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George L. Merrill M.D. | | Sept. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/27/49 | Mt Auburn | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 26 1949 | Deputy for Williams, M.D. | Geo. H. Nelson | 903 937 Pleasant St |

G78436

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

157

Registered No. G78436

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD GREEZICKI

2. DATE OF DEATH Sept. 24, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1250 N. Gay Street

c. Length of stay in Baltimore 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1250 N. Gay Street E-07

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Mar. 15, 1883

9. AGE (In years last birthday) 66 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ignatius Greezicki

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-2253

17. INFORMANT 3101 Batavia Ave. ADDRESS 14 Mr. Ignatius Greezicki

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION May 1949

19B. MAJOR FINDINGS OF OPERATION Cancer of Pancreas with metastases

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. I hereby certify that I saw the deceased in August 1949 to ____, 19__, that I last saw the deceased alive on Aug. 2, 1949, and that death occurred at 2:30 A m., from the causes and on the date stated above.

23A. SIGNATURE William H. Keating M. D.

23B. ADDRESS 11 E. Chase St.

23C. DATE SIGNED 9-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 9/27/49

24C. NAME OF CEMETERY OR CREMATORY Holy Rosary

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 469

123567
78437
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78437

1. NAME OF DECEASED (Type or Print): George Rogers

2. DATE OF DEATH: 9-24-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Erdman Ave., and Belair Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Single | Aug. 21-1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: ODD JOBS

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Rogers (D

14. MOTHER'S MAIDEN NAME: Emma Nelson (D

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Infarction
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-7- , 19 48 *to* 9-24- , 19 49 *that I last saw the deceased alive on* 9-24- , 19 49 *and that death occurred at* 11.40 AM *from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Rogers M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED: 9-24-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 9/27/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.

ADDRESS: BALTIMORE - 13, MARYLAND

VS 150

94a

G78438

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50 G78438 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Raymond A. Kephart

2. DATE OF DEATH 9/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Maryland Gen. Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1118 E. 36th St. 9-03

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH April 18, 1880
9. AGE (In years last birthday) 69 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David Kephart
14. MOTHER'S MAIDEN NAME Lightner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Sara Kephart ADDRESS 1118 E. 36th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Esophagus — 6 mo.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. [redacted] Hypertensive Heart Disease

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/13 1949 to 9/26, 1949 *that I last saw the deceased alive on* 9/25, 1949 *and that death occurred at* 5 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE Ernest E. Lewis M. D.
23B. ADDRESS Mt Vernon Place
23C. DATE SIGNED 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY Harmony Lutheran
24D. LOCATION (City, town, or county) Mt Harmony (State) ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR C. C. Hunt & Son
Taneytown Md

VS 150

Huntington Williams, M.D.

46a

AB-131930 G78439

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

63 G78439 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Webber (Weber)

2. DATE OF DEATH: 9-24-1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 941 N. Collington Ave. 7-03

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 21-1872
9. AGE (In years last birthday): 77 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Weber
14. MOTHER'S MAIDEN NAME: Catherine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT Records: ADDRESS Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Lung
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertensive Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17-49 *to* 9-24-49, *that I last saw the deceased alive on* 9-24-49 *and that death occurred at* 1.30 PM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 9-24-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 27 '49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park
24D. LOCATION (City, town, or county) (State): Parkwood Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 26 1949
REGISTRAR'S SIGNATURE: [signature] Washington-Wilkinson, M.D.
25. FUNERAL DIRECTOR: Frank Evans Sons
ADDRESS: 900 Edmondson

SEP 26 1950

47

78440

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

177

78440

Registered No.

STH NO.

1. NAME OF DECEASED (Type or Print) Maslin - Mr. Thomas Lawrence

2. DATE OF DEATH 9:15 P.M. Sept 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables - 700 W. 40th St

Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-07
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years-last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | April 17, 1862 | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | | Rock Hall, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Titus Maslin | Frances Vickers |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 3 weeks ± |
| DUE TO (B) | Carcinoma of Prostate with metastases | 1 year ± |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Widespread Arteriosclerosis | 5 years ± |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 18 1949, *to* September 26 1949, *that I last saw the deceased alive on* Sept. 26 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Conrad Wolff M. D. | 11 East Chase St. Baltimore 2 | 9/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 29/49 | Wesley Chapel | Rock Hall - Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | Marvin V. Wallace - Chestertown | |

VS 150

516

8441 G78441

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4501

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amelia C. Kuntz

2. DATE OF DEATH: 9/24/49 11:30 P.M.

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 513 W. 28th St

D. STREET ADDRESS (If rural, give location): 513 W. 28th St. 12-07

3b. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE, MARRIED~~, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11/6/1866
9. AGE (In years last birthday): 82
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian Coble
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Wanda Naylor ADDRESS: 513 W. 28th St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Gangrene Both Ft.
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/6 1949 *to* 9/22 1949 *that I last saw the deceased alive on* 9/22 1949 *and that death occurred at* 11:30 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Weis, M.D.
23B. ADDRESS: 2902 Huntingdon Ave
23C. DATE SIGNED: 9/26/49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 9/28/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150 (Rev.)

107

G78:42

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78:42

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Paul A. Rutherford

2. DATE OF DEATH Sept. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland Baltimore, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3404 Brendan Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Maryland
D. STREET ADDRESS (If rural, give location) 3404 Brendan Avenue 26 03

3a. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feb. 9, 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): foreman
10B. KIND OF BUSINESS OR INDUSTRY: Standard Cap & Molding Co. PLASTIC BOTTLE CAPS
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Melvin H. Rutherford
14. MOTHER'S MAIDEN NAME: Emma A. ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): none
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Kathryn E. Rutherford, ADDRESS 3404 Brendan Avenue

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Post-rheumatic valvular heart disease Mitral stenosis insufficiency; auricular fibrillation | 4 years. |
| DUE TO (B) | Congestive heart failure | 6+ months |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1st, 1949 *to* 26 Sept, 1949 *that I last saw the deceased alive on* 25 Sept., 1949, *and that death occurred at* 2 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John P. Hawkins Jr. M.D.
23B. ADDRESS: 1207 Eutaw Place
23C. DATE SIGNED: 26 Sept. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: Sept. 28, 1949
24C. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24D. LOCATION (City, town, or county) (State): Knoxville, Tennessee

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook, Inc., ADDRESS 1217 St. Paul Street

VS 150

92 C

G78443

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

G78443

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): MORRIS BLUMBERG

2. DATE OF DEATH: 9-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN. HOSP.

c. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21 02
D. STREET ADDRESS (If rural, give location): 4501 Liberty Heights Ave

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
AGE (In years, last birthday): 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Home Lighting Co ELECTRAL SUPPLIES
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob
14. MOTHER'S MAIDEN NAME: Minnie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Blumberg ADDRESS: 4501 Liberty Hgts

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO-VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CHRONIC NEPHRITIS
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/25/49 *to* 9/26/49 *that I last saw the deceased alive on* 9/26/49 *and that death occurred at* 2:00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: M. D.
23B. ADDRESS: WB & A
23C. DATE SIGNED: 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-27-49
24C. NAME OF CEMETERY OR CREMATORY: Sherrei Tiloh
24D. LOCATION (City, Town or County) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

1210

G78:44 ✓ G78:44

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Esta Gotek

2. DATE OF DEATH: 9-25-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 437 North Exeter St.

3A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

3C. Length of stay in Baltimore: 12 Yrs. ~~Mos.~~ ~~Days~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | March 23-1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Lillie Cunningham | U.S.A. |

13. FATHER'S NAME: Harvey Mullins

14. MOTHER'S MAIDEN NAME: Adam Gotek 437 N. Exeter St

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 234-10-6960 | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) 1. Carcinoma of Cervix | 2 yr. |
| | DUE TO | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Uremia | 4 mos. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-6, 19 47 *to* 9-25, 1949, *that I last saw the deceased alive on* 9-25, 1949, *and that death occurred at* 9 25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Margaret L. Shepard M. D. | Mercy Hospital | 9-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~or CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 28-1949 | St Stanislaus | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Contractor Williams, M.D. | George A. Weber | 705 S. Conkling St |

VS 150

48a

Fisher

78445

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78445

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Elmer Lloyd
2. DATE OF DEATH: 9/24/49
3. PLACE OF DEATH: a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2214 Kentucky Ave
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE: Md; b. COUNTY; c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto; d. STREET ADDRESS (If rural, give location): 2214 Kentucky Ave E of
5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~ MARRIED, ~~WIDOWED~~ ~~DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 2/28/1895
9. AGE (In years last birthday): 54; If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire Alarm/Telegraph
10B. KIND OF BUSINESS OR INDUSTRY: Fire Dept City
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Robert Lloyd
14. MOTHER'S MAIDEN NAME: Estella E. Ensor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Lloyd ADDRESS: 5402 Redington Way

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Massive Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Sudden Sick 24 hrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/24 49 *to* 9/24 49, *that I last saw the deceased alive on* 9/24 49, *and that death occurred at* 745P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 705 Medical Arts Balto Md
23C. DATE SIGNED: 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/27/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: [signature] Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150 Geo. McLean 94a

G78446 331 G78446

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No. G 78446

1. NAME OF DECEASED (Type or Print): Emma J. Herbert

2. DATE OF DEATH: Sept. 26, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 806 E. North Avenue

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 806 E. North Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 18, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | - | Baltimore, Maryland | U.S. |

13. FATHER'S NAME: August Keim

14. MOTHER'S MAIDEN NAME: Elizabeth Reese

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | Mr. J. Francis Herbert, Sr. 806 E. North Avenue |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage left with | 11 days |
| | DUE TO Rt. Hemeplegia | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerosis | ? |
| | DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Hypertension | 10 yrs. plus |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-15- , 1949, *to* 9-26- , 1949, *that I last saw the deceased alive on* 9-25- 1949 *and that death occurred at* 3:5[illegible] A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph J. Hills M.D. | 18 E Eager St Balto 2nd | 9-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town) (State) |
|---|---|---|---|
| Burial | 9-29-49 | Ceder Hill Cemetery | Annapolis Blvd, Brooklyn, |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 9-27-49 | Huntington Williams, MD | George J. Ruth, Inc. | 1735 Harford Ave |

VS 150

832

78447 G78447

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES R. JONES

2. DATE OF DEATH: Sept. 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 643 W. Lafayette Ave.
c. Length of stay in Baltimore: 28 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 643 W. Lafayette Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Single | Oct. 28, 1919 | 29 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | NONE | Virginia | U. S. A |

13. FATHER'S NAME: Robert Jones

14. MOTHER'S MAIDEN NAME: Mary Moore

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs. Mary Boyd 643 W. Lafayette Av. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Tuberculosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* — 19 37, *to* Sept 26, 1949 *that I last saw the deceased alive on* Sept 26 1949 *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dan Saunders M. D. | 1 W. Lee St | 9/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-28-49 | Arbutus Mem. Park | Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | Mrs. Frances A. Hensley-Biddle & | 578 W |

VS 150

13B

MEDICAL EXAMINER'S CASE RELEASED

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 38148

1. NAME OF DECEASED (Type or Print) Elizabeth Valeska Saal

2. DATE OF DEATH Sept. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's

c. Length of stay in Baltimore 79 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4411 Parkmont Ave.

5. SEX F.

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 9-2-1862

9. AGE (In years last birthday) 87 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) GERMANY

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ? DORMAN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Frank Saal ADDRESS 4411 Parkmont Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Simple comminuted intertrochanteric fracture - left femur — INTERVAL BETWEEN ONSET AND DEATH 34 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Trauma (fall) at home

DUE TO

CERTIFICATION APPROVED BY

For: Wm. G. Helfrich M. D. ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C) Arteriosclerotic heart disease
Hypostatic pneumonia

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4411 Parkmont Ave

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY August 26, 1949 ? m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fall - fell to the floor

22. *I hereby certify that I attended the deceased from* 9-21, 1949 *to* 9-25, 1949 *that I last saw the deceased alive on* 9-24-, 1949, *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE J. Jasper Krejci M. D.

23B. ADDRESS 1400 N. Caroline St.

23C. DATE SIGNED 9-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9-28-49

24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.

24D. LOCATION (City, town, or county) (State) GERMAN HILL RD.

DATE RECEIVED BY LOCAL REGISTRAR SEP 27 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Richards L. Zeiler ADDRESS 901 S Conkling St.

VS 150

Krejci

186a

3449 G78449

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK KAMINSKI
2. DATE OF DEATH: 9/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: (?) 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 210 SLIMMER ALLEY

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 12/4/894 | 54 | 9 | 10 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MECHANIC | — ? | Chicago Ill | U.S.A. |

13. FATHER'S NAME: Jack KAMINSKI
14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| YES Yes First WW | 216-03-0898 | WIFE | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure
DUE TO
(B) Cardiac failure
DUE TO
(C) Cerebral anoxia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Tetanus - infected right hand & fingers

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

CERTIFICATION APPROVED BY
R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/17/49 | Infected compound fracture right hand & fingers amputation of | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident | farm | High Rock, Pa. ? (DJM) |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 9 14 49 ? m. | WHILE AT WORK ☒ ? NOT WHILE AT WORK ☐ | Fell to ground (DJM) |

22. *I hereby certify that I attended the deceased from* 9/17/ *, 1949, to* 9/22/ *, 1949, that I last saw the deceased alive on* 9/22/ *, 1949, and that death occurred at* 5 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. O. Leuchtenberg M. D. | University Hospital | 9/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/27/1949 | Holy Redeemer Cemetery Belair Road-Baltimore, Md. | |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | Grauel Dallahan | 322 S. High St. |

VS 150

12

8450

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 678450

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Angelo Natale**

2. DATE OF DEATH **September 25-49**

3. PLACE OF DEATH: A. **Baltimore City, Maryland** **120 S. Exeter St.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore **48 Yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **120 S. Exeter St.**
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **120 S. Exeter St.**

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| **Male** | **White** | **Widow** | **October 30 1880** | **68** | **10** | **26** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **Laborer** | **Odd Jobs** | **Nusco Italy** | **U.S.A.** |

13. FATHER'S NAME **Luigi Natale**

14. MOTHER'S MAIDEN NAME **Maria Prudente**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT **Louis Natale (Son)** ADDRESS **921 Fawn St.**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Hypertensive cardio-vascular-renal disease**

DUE TO

(B) **Arterio-sclerosis.**

DUE TO

(C) **Cerebral Thrombosis**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **Sept 17**, 19**45** *to* _____, 19___, *that I last saw the deceased alive on* **Sept 17**, 19**45**, *and that death occurred at* **11 3/4** *m., from the causes and on the date stated above.*

23A. SIGNATURE **M. A. Finia** M. D. | 23B. ADDRESS **110 Biscayne** | 23C. DATE SIGNED **9/26/45**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** | 24B. DATE **Sept. 28 1949** | 24C. NAME OF CEMETERY OR CREMATORY **Holy Redeemer Cemetery** | 24D. LOCATION (City, town, or county) (State) **4430 Belair Rd Baltimore Md.** ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 27 1945 | REGISTRAR'S SIGNATURE **Huntington Williams, M.D.** | 25. FUNERAL DIRECTOR **Frank Della Rose** **322 S. High St.**

VS 150

131a

78451

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78451

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTIN SWIGON

2. DATE OF DEATH: September 24, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2807 Erdman Avenue

c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2807 Erdman Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | November 7, 1872 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Poland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| --- | | --- | Mary Swigon | 2835 Mayfield Avenue |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremic poisoning | 2 mos |
| DUE TO (B) | Cardio-vascular Renal Disease | ? |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Generalised arterio-sclerosis & prostatic hyper Trophy | ? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-15- *1949 to* 9-23- *1949 that I last saw the deceased alive on* 9-23- *1949, and that death occurred at* 8 45 A. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fulton C. Lang M. D. | 2117 Belair Rd | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/28/49 | Holy Rosary | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Funeraltor Williams, M.D. | M.F. Sadowski & Sons | 1808 Eastern Avenue |

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78352 ✓ 1 78452

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Maggie L. Jackson

2. DATE OF DEATH Sept. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1706 Latrobe St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1706 Latrobe St.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1706 Latrobe St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1706 Latrobe St 12-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | married | Oct. 15, 1893 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Restaurant | Gloucester Co., Va. | U.S.A. |

13. FATHER'S NAME William H. Banks

14. MOTHER'S MAIDEN NAME Sarah E. Jackson.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Eliza Mae Myers ADDRESS 1706 Latrobe St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Sept 15, 1949 to Sept 23, 1949 that I last saw the deceased alive on Sept 22, 1949, and that death occurred at 24 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jas. Julian Jr. M. D. | 5117 N. Schroeder St. | Sept 26-'49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 9-27-1949 | W. H. Calvary Cem | Odenton Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 322 N Schroeder St |

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CERTIFICATE CORRECTED 10-6-49

G78453

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78453

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES LEMKI (OR) LAMKE

2. DATE OF DEATH Sept. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2012 Fountain St. 2-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | ~~Married~~ Single | July 21, 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Barge Captain | | Maryland | U.S. |

13. FATHER'S NAME John Lemki

14. MOTHER'S MAIDEN NAME Catherine Swider

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| ? | | |

17. ~~BROTHER~~ BROTHER IN LAW. ADDRESS Philip Richwalski 323 S Regester St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Heart Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 6, 1949 *to* Sept. 26, 1949, *that I last saw the deceased alive on* Sept 26, 1949, *and that death occurred at* 12 [illegible] a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Luttel Jr. M. D. | Mercy Hosp. | 9/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT 27 1949 | MOUNT CARMEL | O DONNELL ST MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | Duffel Bros. | 1800 E LOMBARD ST |

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G784:54

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G784:54

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE ETHLAN THOMAS

2. DATE OF DEATH: Sept. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3313 St. Paul St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3313 St. Paul St. 1202

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Jan. 16, 1863
9. AGE (In years last birthday): 86 yrs. (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): York Co., Pa.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John Grove
14. MOTHER'S MAIDEN NAME: Hariette Prall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Charles Curlander
ADDRESS: 3605 Grantley Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) General Arterio Sclerosis — 10 yrs

DUE TO

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1, 1942 *to* Sept 25, 1949, *that I last saw the deceased alive on* Sept 24, 1949, *and that death occurred at* 1 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Emmett R. Wagner M. D.
23B. ADDRESS: 806 Cathedral
23C. DATE SIGNED: 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/27/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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78455

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

No. 1 078455 Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | OLIVER LEE OWENS |
| 2. DATE OF DEATH | Sept. 25, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 3005 Westwood Ave. |
| C. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 3005 Westwood Ave. 15-06 |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Mar. 10, 1891 |
| 9. AGE (In years last birthday) | 58 yrs. |
| If Under 1 Year: Months / Days | |
| If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Special Revenue Agt. |
| 10B. KIND OF BUSINESS OR INDUSTRY | U. S. Governm't |
| 11. BIRTHPLACE (State or foreign country) | A. A. Co., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Oliver S. Owens |
| 14. MOTHER'S MAIDEN NAME | Cassie R. Hancock |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | yes |
| (If yes, give war or dates of service) | World War #1 |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT | Mrs. Madeline C. Owens |
| ADDRESS | 3005 Westwood Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Coronary Sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | |
|---|---|
| 19A. DATE OF OPERATION | |
| 19B. MAJOR FINDINGS OF OPERATION | |
| 20. AUTOPSY? YES ☐ NO ☐ | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | |
| 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |
| 21F. HOW DID INJURY OCCUR? | |

22. *I hereby certify that I attended the deceased from* January, 1949, *to* Sept. 25th, 1949 *that I last saw the deceased alive on* Sept 25, 1949, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| Julius C. Gleach M. D. | 5356 Reisterstown Rd | 9/22/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial | 9/28/49 | Baltimore National Cem. |
| 24D. LOCATION (City, town, or county) (State) | | |
| Balto., Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
| SEP 27 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS — Balto., Md. |

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G78456

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

81.0 G78456 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK DANTONI

2. DATE OF DEATH SEPT. 24/49

3. PLACE OF DEATH: Baltimore City, Maryland BALTO CITY

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 24-03
D. STREET ADDRESS (If rural, give location) 1452 WILLIAM ST.

3A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE GENERAL

3C. Length of stay in Baltimore Yrs. LIFE Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | WIDOWED | SEPT. 19-1887 | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HELPER | PRODUCE | BALTO. Md. | |

13. FATHER'S NAME JOSEPH DANTONI

14. MOTHER'S MAIDEN NAME LUCY POLIGARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 212-03-2209

17. INFORMANT Joseph Dantoni ADDRESS 1452 William St.

## MEDICAL CERTIFICATION

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CIRCULATORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) PERICARDIAL & PLEURAL EFFUSIONS

DUE TO

(C) PORTAL CIRRHOSIS OF LIVER

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 9/16, 1949 to 9/24, 1949, that I last saw the deceased alive on 9/24, 1949, and that death occurred at 9:45 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel P. Scalia M. D. | 1213 Light Street | 9/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT. 28/49 | OAKLAWN | BALTIMORE Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 27 1949 | Huntington Williams, M.D. | KRAUSE FUNERAL HOME 1216 S. CHARLES ST. |

VS 150

124 B

30

G78457

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

41 6 G78457

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): HARRISON, LOUIS H. JR. (OR LEWIS)

2. DATE OF DEATH: 9-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQ. HOSP BALTO 23

C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE MD.
D. STREET ADDRESS (If rural, give location): 2000 BRADDISH AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | 12-10-1905 | 43 | 9 / 16 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NOT ON RECORD
10B. KIND OF BUSINESS OR INDUSTRY: RACE TRACK
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: LEWIS H. HARRISON SR.
14. MOTHER'S MAIDEN NAME: ELLEN VIRGINIA HARRISON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: MRS HELEN DANIELS ADDRESS 2000 BRADDISH AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B) Rheumatic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: NOT DET.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 26, 1949 *to* Sept 26, 1949, *that I last saw the deceased alive on* Sept 26, 1949 *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. W. Bohemie M. D.
23B. ADDRESS: Franklin Sq Hosp
23C. DATE SIGNED: 9-26-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-29-49 | Lorraine Park | Woodlawn, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150 272-90 95C

G78458

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 44 Registered No. G78458

1. NAME OF DECEASED (Type or Print) Samuel Nichols

2. DATE OF DEATH Sept. 23-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 924-N Gay st

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 824. N. Gay. st 10-62

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | W. | Jul 3. 1873 | 76 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore - Md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mary Purnell ADDRESS 507-N. Ensor st

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis and Hemiplegia

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) Indefinite 1 month

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/21/49 *to* 9/23/49, *that I last saw the deceased alive on* 9-23-49, *and that death occurred at* 3:45 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE Jos. R. Blake M. D. 23B. ADDRESS 1163-N. Carolina 23C. DATE SIGNED 9-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial 24B. DATE Sept-28-49 24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary 24D. LOCATION (City, town, or County) (State) Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1631 Hanover Ave

93E

G78459

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78459

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bertha R Loncar

2. DATE OF DEATH: Sept 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 507 S. Macoh St.

c. Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 507 S Macon
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-07
D. STREET ADDRESS (If rural, give location): 507 S Macon

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Mar 13 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Cecko Slovokia | |

13. FATHER'S NAME: Martin Dermak

14. MOTHER'S MAIDEN NAME: Mildred

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | George Loncar | 507 S Macon S t |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancerous Metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(B) Carcinoma of Liver — 6 months

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 1st, 1949, to Sept 26, 1949, *that I last saw the deceased alive on* Sept 26, 1949, *and that death occurred at* 1:50 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Michael A Adams M.D. M. D. | 1811 Eutaw Place | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 29/49 | Holy Redeemer | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Huntington for Williams M.D. | Wilmot Funeral Home | 2008 Orleans St |

VS 150

46F

G78460

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331 Registered No. G78460

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amelia Norris Murray

2. DATE OF DEATH: 9-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Geddis Nursing Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elkridge
D. STREET ADDRESS (If rural, give location): Montgomery Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 3-14-1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Taylor Keys
14. MOTHER'S MAIDEN NAME: Rebecca Smith Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Daniel Murray, ADDRESS: Elkridge, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Haemorrhage
DUE TO
(B) Arterio Sclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1949, *to* Sept 25, 1949, *that I last saw the deceased alive on* Sept 24, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter G Bartlett M. D.
23B. ADDRESS: 1101 St Paul St
23C. DATE SIGNED: Sept 26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-27-49
24C. NAME OF CEMETERY OR CREMATORY: St. Johns
24D. LOCATION (City, town, or county) (State): Ellicott City, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR, ADDRESS: F.C. Higinbothom, Ellicott City, Md.

VS 150

83a

BIRTH NO. 078461

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078461

1. NAME OF DECEASED (Type or Print): JOHN STANLEY ALER

2. DATE OF DEATH: 9/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Calvert & 33 Sts
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: 60 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALT
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 18
D. STREET ADDRESS (If rural, give location): 1605 CHILTON STREET 9-c 6

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 16 OCT 1889
9. AGE (In years last birthday): 59 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ACCOUNTANT
10B. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JOHN A. ALER
14. MOTHER'S MAIDEN NAME: EULA FOSTER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO:
17. INFORMANT: ~~WIFE~~ alice Aler (wife) ADDRESS: SAME (1605 Chilton)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease
due to
(B) nephrosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Duodenal ulcer

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/13, 1949, to 9/25, 1949, *that I last saw the deceased alive on* 9/25, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles H. Watt Jr. M. D.
23B. ADDRESS: Union memorial Hospital
23C. DATE SIGNED: 9/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: Sept 28/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md
DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Contingent for Williams, M.D.
25. FUNERAL DIRECTOR: Steward Mortuary
ADDRESS: Balto.

VS 150

1310

MILLER X 54-5 078462

B. Med Exams Case

Blessed & Hosp.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Edward Miller

2. DATE OF DEATH: Sept 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Ohio; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Martins Ferry

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 114 Virginia St

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: 9-19-40

9. AGE (In years last birthday): 9

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Silvertius Miller

14. MOTHER'S MAIDEN NAME: Regnea Raab

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coarctation of the aorta juvenile type | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY

R. H. Kimber M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9/14 19 49 *to* 9/27 19 49 *that I last saw the deceased alive on* 9/27 19 49 *and that death occurred at* 9:50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Wallace M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 9/30/49

24C. NAME OF CEMETERY OR CREMATORY: Martins Ferry Ohio Cem.

24D. LOCATION (City, town, or county) (State): Martins Ferry, Ohio.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home Inc. 2601-03-05 E. Madison St.

VS 150

To be approv. by Med. Exam

157F

G78463

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78463

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM HUNTER CHAPMAN, SR.

2. DATE OF DEATH: 9/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE Catonsville
D. STREET ADDRESS (If rural, give location): 220 MT DESALES RD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN HOSP.

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months Days | If under 24 hours: Hours Min. |
|---|---|---|---|---|---|---|
| M | W | WIDOWED | JULY 17, 1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| REPAIR PIPE FITTER | B & O R.R. | | |

13. FATHER'S NAME: JAMES CHAPMAN

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | MR JAMES CHAPMAN | 2925 ROKEBY RD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 9/21/49 9/26/49 |

22. *I hereby certify that I attended the deceased from* 9/21/49, 19__, to 9/26/49, 19__, *that I last saw the deceased alive on* 9/26/49, 19__, *and that death occurred at* 6P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. H. GOLDMEER M. D. | W B & H | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | SEPT 29'49 | LORRAINE PK | WOODLAWN, MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 27 1949 | Lillington Williams, M.D. | HARRY HW, JR E - 4101 EDMONDSON | 40[illegible] |

VS 150

94a

G78464

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78464

1. NAME OF DECEASED (Type or Print) James O. Beaumont

2. DATE OF DEATH Sept. 26/49

3. PLACE OF DEATH: (a) Baltimore City, Maryland Baltimore, Md.

(b) FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 318 S. Mount St.

(c) Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 318 S. Mount St. 19-84

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 23, 1868 | 9. AGE (In years last birthday) 80 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME A. H. Beaumont

14. MOTHER'S MAIDEN NAME Margaret Schaefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (wife) ADDRESS Mrs. Emma Beaumont, 318 S. Mount St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2wks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) none

DUE TO

(C) none

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/12, 19 49, *to* 9/26, 19 49, *that I last saw the deceased alive on* 9/26, 19 49 *and that death occurred at* 9/26 *m., from the causes and on the date stated above.*

23A. SIGNATURE Benjamin Miller, MD M. D. | 23B. ADDRESS 2030 Wilkens ave | 23C. DATE SIGNED 9/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Sept. 29/49 | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery | 24D. LOCATION (City, town, or county) (State) 3801 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR SEP 27 1949 | REGISTRAR'S SIGNATURE Evelyn for Miller, MD | 25. FUNERAL DIRECTOR Harry H. Lintz | ADDRESS 4101 Edmondson Ave.

VS 150

93D

G78465

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78465 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marguerite Casey — MARGUERITE M. CASEY

2. DATE OF DEATH 9/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen. Hospital
c. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 716 E. Chase street 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | S | Aug. 20, 1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: John A. Casey

14. MOTHER'S MAIDEN NAME: Margaret E. Glenn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mrs. Thomas Keavney | 430 E. 22nd st. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Probable tuberculous sanitation of left upper lobe | 6½ mo ? |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-21, 1949, *to* 9-24, 1949, *that I last saw the deceased alive on* 9-24 1949, *and that death occurred at* 8:18 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Katherine V. Kemp M. D. | West Balto Gen. Hosp | 9/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/28/49 | New Cathedral | Baltimore, Maryland |

DATE RECEIVED BY LOCAL REGISTRAR SEP 27 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS

Chas. S. Evans & Son Inc.
13B 118 N. Mt. Royal Ave.

VS 150

78466

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. 50.1 G78466

1. NAME OF DECEASED (Type or Print): Randolph, George

2. DATE OF DEATH: 9/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1514 Division St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5065 [redacted] Lafayette Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | 12/28/92 | 56 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richmond Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Secondary Shock — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Generalized Peritonitis
DUE TO
(C) Appendical Abscess
Acidosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 8/29/49 | Appendical Abscess - Peritonitis | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/28 1949 *to* 9/2 1949 *that I last saw the deceased alive on* 9/2, 1949 *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr Marcus W. Moore M. D. | Provident Hospital | 9/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | SEP 27 1949 |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.
FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

121

G78467

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78467

BIRTH NO. B.C. 49-80438

1. NAME OF DECEASED (Type or Print): BABY GIRL Cole

2. DATE OF DEATH: 9-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore Gen. Hosp.

c. Length of stay in Baltimore: 2 hrs 24 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severn
D. STREET ADDRESS (If rural, give location): New Cut Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | W | SINGLE | 9-23-49 | | | 2 / 24 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNEmployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Edward Cole

14. MOTHER'S MAIDEN NAME: Dorothy Elizabeth Gastiger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother ADDRESS: New Cut Rd Severna Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Hydrocephalus

DUE TO

(C) SPINA Bifida

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-23, 1949 *to* 9-23, 1949, *that I last saw the deceased alive on* 9-23, 1949, *and that death occurred at* 7:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: James L. Gray M. D.

23B. ADDRESS:

23C. DATE SIGNED: 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL SEP 27 1949

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS:

VS 150

157a

78468

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Ent. 4 G78468

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CLARENCE DICKERSON N-803-7

2. DATE OF DEATH: September 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1100 North Point Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | | 40 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration of vomitus
DUE TO Fractured skull
(B) Intracranial hemorrhage
DUE TO Contusion of brain
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North Point Road and Bread & Cheese Br/ Baltimore County, Maryland

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 18, 1949 7:35 P. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 9-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY [illegible]

24D. LOCATION (City, town, or county) (State): SEP 27 1949

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS

VS 151

170c

78469

BIRTH NO. 49-20241

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 774 - 78469

1. NAME OF DECEASED (Type or Print): BABY AYE

2. DATE OF DEATH: September 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2502 S. Paca Street 25-43

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | | 9-23-49 | | | 11 / 15 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | [illegible] | |

13. FATHER'S NAME: [illegible] Ayre

14. MOTHER'S MAIDEN NAME: [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity (Gestation circa 200 days)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [ ], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George L. Merrill M.D. | ASSISTANT MEDICAL EXAMINER [X] | Sept. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | SEP 27 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | COMMISSIONER of Health | |

VS 151

159

BS-76401

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 78470 — Registered No. 4700 — 078470

1. NAME OF DECEASED (Type or Print): William Travers

2. DATE OF DEATH: 9-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 67 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1402 McElderry St. 501

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: May 28, 1860
9. AGE (In years last birthday): 89 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ✓
10B. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Silas Travers
14. MOTHER'S MAIDEN NAME: Kattie Tyler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS* BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17, 19 42, *to* 9-19, 19 49 *that I last saw the deceased alive on* 9-19 19 49 *and that death occurred at* 8:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 9-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 9/28/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: Turlington Williams M.D.
25. FUNERAL DIRECTOR: Robert F. Williams
ADDRESS: 1505 McElderry St

VS 150

937

G78471

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78471 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BARBARA BERGER

2. DATE OF DEATH: 9/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4302 Kathland Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4302 Kathland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | II/25/1865 | 83 84 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Ermer - Germany
14. MOTHER'S MAIDEN NAME: Briggitta Miller - Germany
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family - Same ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Thrombosis in femoral artery left leg. no circulation | 4 days |
| DUE TO (B) | complete collapse of circulation in leg. Advanced Arterio-Sclerosis | |
| DUE TO (C) | Myocarditis | about 4 mo |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? yes ☐ no ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 5 '49, 19 , *to* Sept 25, 1949, *that I last saw the deceased alive on* Sept 24, 1949 *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 220 Garrison Blvd
23C. DATE SIGNED: Sept 27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 9/28/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph L. Du Burk ADDRESS - 130 E. Fort Ave.

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78472 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78472

1. NAME OF DECEASED (Type or Print): Thomas Carter

2. DATE OF DEATH: 25 Sept. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital (DOA)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 682 W. Mulberry Street 17-01

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 1881
9. AGE (In years last birthday): 68
If under 1 year: Months / Days; If under 1 day: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher's helper
10B. KIND OF BUSINESS OR INDUSTRY: Lexington Market
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Lorraine Washington - 682 Mulberry

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 25 Sept. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/29/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemet.
24D. LOCATION (City, town, or county) (State): Cedar Hill, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: A. Halstead 918 Druid Hill Avenue

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G78473

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 G78473 Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS KENNARD
2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 164 Dolphin St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 164 Dolphin - St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | C | WIDOWED | 9-23-1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PORTER
10B. KIND OF BUSINESS OR INDUSTRY: O'Sullivan DLDG. - OFFICE
11. BIRTHPLACE (State or foreign country): CHESTERTOWN MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE KENNARD
14. MOTHER'S MAIDEN NAME: HARRIETT RINGGOLD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): UNKNOWN (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 213-16-8789
17. INFORMANT: LAWRENCE KENNARD ADDRESS: 646 PERKINS AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): Chronic Interstitial Nephritis — INTERVAL BETWEEN ONSET AND DEATH: History indefinite

DUE TO:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO:

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1 1949 *to* Sept 26, 1949, *that I last saw the deceased alive on* Sept 26 1949, *and that death occurred at* 7 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Garland Sherwell M.D. | 1534 Druid Hill Ave | Sept. 27 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-1-49 | Mt. Albion Cemetery | A.A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | William A. Jackson | 916 Penna. Ave. |

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78-'74 BALTIMORE CITY HEALTH DEPARTMENT 795.4 678-'74

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE SMALLWOOD

2. DATE OF DEATH September 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex

D. STREET ADDRESS (If rural, give location) 7525 Carson Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Single | 4/18/32 | 17 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME CLIFTON

14. MOTHER'S MAIDEN NAME PAULINE BRUCE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | PAULINE SMALLWOOD | 1525 Carson Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undetermined -795.4

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Emil L Kruse M.D. | | Sept. 27, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Sept 30. 49 | Fork M.E. Cem. | Fork Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | C ARTHUR. | Fork Md. |

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BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 903.5 078475 Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | ASHBY TOLSON N-820 |
| 2. DATE OF DEATH | Sept. 25, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Balto. |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 4703 Hampnett Ave. Pine Ridge Nursing Home |
| D. STREET ADDRESS (If rural, give location) | 2407 W. Lanvale St. 16-05 |
| c. Length of stay in Baltimore | Yrs. Mos. Days |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widowed |
| 8. DATE OF BIRTH | Oct. 6, 1867 |
| 9. AGE (In years last birthday) | 81 yrs. |
| If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Attorney (rtd) |
| 10B. KIND OF BUSINESS OR INDUSTRY | - |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | John Alexander Tolson |
| 14. MOTHER'S MAIDEN NAME | Maria Lambert |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT ADDRESS | Mr. Carroll F. Tolson, Sr.-1834 St. Paul St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Cerebral Hemorrhage | 2 mos. |
| DUE TO (B) | General Arteriosclerosis | 1 yr. |
| DUE TO (C) | Fracture of Femur | 15 mos. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY

W. J. McCafferty M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | Accident | |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | Home | |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | 2407 W. Lanvale St. 16/5 | |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | ? ? m. | |
| 21E. INJURY OCCURRED | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |
| 21F. HOW DID INJURY OCCUR? | Slipped and fell to pavement outside of home | |

22. *I hereby certify that I attended the deceased from* Sept 15 *19* 49 *to* _____ *19* __, *that I last saw the deceased alive on* Sept 25 *19* 49, *and that death occurred at* 8 P. M. *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | M. D. | 23B. ADDRESS 6 E Biddle St |
| 23C. DATE SIGNED | 9/27/49 | |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | 9/28/49 | Woodlawn Cem. | Woodlawn, Md. |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| SEP 28 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

99-7 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Skinner, Helen Elizabeth

2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1629 Poplar Grove St. 15-06

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: Sept. 4, 1883
9. AGE (In years last birthday): 66 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10B. KIND OF BUSINESS OR INDUSTRY: J. W. Fitzpatrick Co
11. BIRTHPLACE (State or foreign country): Midland, Mich.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Henry Skinner
14. MOTHER'S MAIDEN NAME: Agatha Mildred Windover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Charles A. Skinner ADDRESS: 1629 Poplar Grove St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the gall bladder,
DUE TO metastatic, generalized to cerebral
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3-4 mos

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9 19 49 *to* 9-27 19 49 *that I last saw the deceased alive on* 9-27 19 49, *and that death occurred at* 2:25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Marvin H. Davis M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 9-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 9/28/49
24C. NAME OF CEMETERY OR CREMATORY: Midland
24D. LOCATION (City, town, or county) (State): Midland, Mich.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

210

46F

78-77

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 Registered No. G78-77

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THEODORE Victor DENIS

2. DATE OF DEATH September 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2624 W. Franklin Street 20-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Widowed | Aug. 11, 1888 | 61 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Balto. Transit Co. | Baltimore, Md. | |

13. FATHER'S NAME
Albert E. Denis

14. MOTHER'S MAIDEN NAME
Rebecca B. Seabreeze

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT · ADDRESS |
|---|---|---|
| no | | Mrs. Madeline Farnoff - 2624 W. Franklin St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Sept. 27, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

93D

G78478

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3.1 35 G78478

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELEANOR SCHULTZ
2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for the Women of Maryland
c. Length of stay in Baltimore: Yrs. — Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 2032 N. Wolfe St., City-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | married | 3-5-87 | 62 | 6 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H. W. | | Bradshaw, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Elias Carbue | Margaret Pheiffer |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | John Lewis Schultz | Sayre |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO Unknown cause

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Grand mal epilepsy

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-31, 1949 *to* 9-27, 1949, *that I last saw the deceased alive on* 9-27, 1949, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. P. Benson, Jr. M. D. | Women's Hosp. | 9-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Parkwood | Taylor Av. Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Mildred D. Blight | 6009 Harford Rd |

VS 150

8 3a

correct age is especially important. Typewriter preferred.

78479

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

40-1 G78479 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Axel Boethius

2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 7 Yrs. 10 Mos. Years Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-1
D. STREET ADDRESS (If rural, give location): Wentworth Arms Apts - Mulberry St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | July 28 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Physiotherapist. | SELF | Sweden | U.S.A. |

13. FATHER'S NAME: Albert Wilhelm Boethius

14. MOTHER'S MAIDEN NAME: Emma Marianne Enestrom.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism, left — (INTERVAL BETWEEN ONSET AND DEATH) 36 hours

DUE TO

(B) Phlebothrombosis

DUE TO

(C) Post operative complication

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Metastatic carcinoma - hepatic

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-19-49 | Perforated Peptic Ulcer | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-19 1949 *to* 9-27 1949 *that I last saw the deceased alive on* 9-27 1949 *and that death occurred at* 9 45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. F. Cox M. D. | Union Memorial Hospital | 9/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Parkwood | Taylor Av. Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Mildred J. Blight, 6009 Harford Av |

VS 150

V8292

46F

Correct age is especially important. Typewriter preferred.

G78480

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78480

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HORACE BETHEL

2. DATE OF DEATH: SEPT. 25. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1824 W. Fairmount Ave.
c. Length of stay in Baltimore: Yrs. 20 Mos. - Days 01

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1824 W. Fairmount Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | April 22/1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired. FITTER | B.O.R.R | Ireland | USA. |

13. FATHER'S NAME: Joseph Bethel

14. MOTHER'S MAIDEN NAME: Mary Gibbons

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | No. | None. | J.Raymond Bethel | (same) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of descending Colon — Interval between onset and death: Abt. 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary Oedema Myocardial failure. — Abt. 2 wks

DUE TO

(C) Arteriosclerosis — Rectal fistula — 5 to 6 years; 3 mo.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 2/17/49 | Carcinoma of Colon | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5/1, 1944 *to* 9/25, 1949, *that I last saw the deceased alive on* 9/25/ 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Theodore H. Morrison M. D. | 11 E. Chase Street | 9/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | SEPT. 28/49 | MEADOWRIDGE ME M. PARK. | DORSEY MARYLAND |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | F.B.WIPPERT & SON..1300 Futon Pl.17 |

VS 150

46E

G78481

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 70 G78481

1. NAME OF DECEASED (Type or Print): Catherine T. McGuirk
2. DATE OF DEATH: 9/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 24 S. Mount St.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 24 S. Mount St. 19-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 11/12/1880 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailoring | St. P. Pants Co. | Baltimore Md. | USA |

13. FATHER'S NAME: John McGuirk
14. MOTHER'S MAIDEN NAME: Catherine McGee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James McGuirk ADDRESS: 24 Mount St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 Months

DUE TO

(B) Carcinoma Right breast — 6 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1 1949 *to* Sept 27, 1949 *that I last saw the deceased alive on* Sept 27, 1949, *and that death occurred at* 8 30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Raevsin M. D.
23B. ADDRESS: 206 S. Gilmor St.
23C. DATE SIGNED: 9-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/1/49
24C. NAME OF CEMETERY OR CREMATORY: St Peters Cem.
24D. LOCATION (City, town, or county) (State): Moreland Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: [illegible] for William, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 50 Hollins St.

VS 150 36006

078:82

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 078:82

1. NAME OF DECEASED (Type or Print): YETTA LEVIN

2. DATE OF DEATH: 9/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore: 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2611 Whitney Ave 27-19

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Russia | |

13. FATHER'S NAME: Nathan Friedman

14. MOTHER'S MAIDEN NAME: Majorie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Robert Blake | 2611 Whitney Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis with Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Coronary Sclerosis

DUE TO

(C) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 26, 19 49, *to* Sept 27, 19 49, *that I last saw the deceased alive on* Sept 27, 19 49 *and that death occurred at* 10 SEP *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leon E. Kassel M. D. | Sinai Hospital | 9/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 28, 1949 | Southern Ave Cemetery | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Hunting for Williams, M.D. | Sol Levinson & Bros | 1126 W. North Ave |

VS 150

937

Correct age is apparently approximate. Registrar's signature illegible.

G78483

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78483

1. NAME OF DECEASED (Type or Print): Lena Arenberg

2. DATE OF DEATH: Sept 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2476 Shirley Ave
c. Length of stay in Baltimore: 48 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 125 N Ann St 6-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 1880 | 69 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Emanuel Itzacowitz

14. MOTHER'S MAIDEN NAME: Mollie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Morris Arenberg ADDRESS: 2611 Vilcet Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Diabetes Mellitus — 10 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949 *to* Sept. 27, 1949 *that I last saw the deceased alive on* Sept 27, 1949, *and that death occurred at* 5.45 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert Hunnefeld M. D. | 1401 Eutaw Pl | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 28, 1949 | Southern Ave Cem | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North Ave

VS 150

61

G78484

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78484

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry Rick (Henry August Rick)

2. DATE OF DEATH: Sept 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Dales 6

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Life (Yrs. / Mos.)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1138 E. North Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Widower | 5-5-95 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service repairman

10B. KIND OF BUSINESS OR INDUSTRY: Modern Appliance Co

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rudolph Rick

14. MOTHER'S MAIDEN NAME: Josephine Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-16-3260

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary artery sclerosis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/22 19 49 *to* 9/26 19 49, *that I last saw the deceased alive on* 9/26 19 49, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter R. Arms M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 9/29/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS: BALTIMORE - 13, MARYLAND

VS 150 336 68

94a

correct age is especially important. Physicians: please write the causes of death in terms understood by the laity.

G78485

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 177

G78485 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HERMAN HEIEN

2. DATE OF DEATH: Sept. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HAMILTON ARMS NURSING HOME

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4511 Harcourt Road 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | Aug. 24, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stove Mounder | Weiskittel Stove Co. | Maryland | USA |

13. FATHER'S NAME: Herman Heien

14. MOTHER'S MAIDEN NAME: Mary A. Goehlke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT ADDRESS: Henry C. Miller - Baltimore Ave, Ocean City, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PULMONARY METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 6 wks
DUE TO
(B) PROSTATIC CARCINOMA
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 1, 19 49 *to* Sept 26, 19 49, *that I last saw the deceased alive on* Sept 26, 19 49, *and that death occurred at* 7 35 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert B. Tunney M. D. | 920 E Fayette St | 9/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 9/28/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. |

VS 150 49630 (R)

BALTIMORE - 13, MARYLAND 51B

Correct age is especially important. Please answer every question.

G78486

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 416

G78486

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thos. L. Hopkins

2. DATE OF DEATH 9/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5212 Caroline St.
C. Length of stay in Baltimore 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-04
D. STREET ADDRESS (If rural, give location) 931 N. Washington St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | CR | Separated | 4/17/1897 | 52 | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Porter | ODD JOBS | Starks Md. | U.S.A. |

13. FATHER'S NAME Lee Hopkins

14. MOTHER'S MAIDEN NAME Olivia Powell

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 215-05-6448 | Mrs Nott. | 5212 Caroline St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Rheumatic Carditis & Failure | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 4-7-49 to 9-24, 19 49 that I last saw the deceased alive on 9-24 1949 and that death occurred at 9:45 p.m. from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. E. Brady Jr. M. D. | President St | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/28/49 | Mt. Calvary | Jesse Arundel County |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Robert L. Young | 1532 E. Monument St. |

VS 150

95B

Correct age is especially important. Physician: please write the cause of death in clear terms.

G78487 ✓ 4 G78487

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Georgia A. Brown
2. DATE OF DEATH: 9/24/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 610 Archer St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-0
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
D. STREET ADDRESS (If rural, give location): 610 Archer St.
6. SEX: Female
7. COLOR OR RACE: Col
8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
9. DATE OF BIRTH: Jan. 1, 1882
10. AGE (In years last birthday): 67 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF (WHAT COUNTRY?): U.S.A.
13. FATHER'S NAME: Edward Simms
14. MOTHER'S MAIDEN NAME: unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John J. Brown ADDRESS: 610 Archer St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 7

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial Failure — 1-15-49

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 7-15 *,* 19 49 *to* 9-24 *,* 19 49 *that I last saw the deceased alive on* 9-24 *,* 19 49 *and that death occurred at* 6:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles T. Wedell M. D.
23B. ADDRESS: 610 Hollins St
23C. DATE SIGNED: 9-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/28/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949

25. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 150

520 Pl 927

correct age is especially important. Physicians: please write the causes of death legibly and spell

G78488

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4500 G78488 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Badger — 2. DATE OF DEATH 9/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 211 N. Carlington Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18

c. Length of stay in Baltimore 45 yrs Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 211 N. Arlington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | | 3/10/1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Unemployed | Eastern Shore, Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Badger | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | 218-07-3913 | Joseph A. Lively - 661 W. Barre St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* [Autopsy, Inspection or Inquiry] *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| | | 9-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 9/29/49 | Mt. Auburn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Charles A. Rice | 661 W. Barre St. |

VS 151

97

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

E. Allen

78489

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Vol. 1 G78489

Registered No.

1. NAME OF DECEASED (Type or Print): Brittania L. Denton

2. DATE OF DEATH: Sept. 27-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4700 Harford Rd. Snyders Nursing Home

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 5315 Elsrode Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | single | 3-9-1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Baltimore Md. | |

13. FATHER'S NAME: Basil B. Denton

14. MOTHER'S MAIDEN NAME: Sue V. Biscoe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Alma Cook ADDRESS: 5315 Elsrode Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — Interval between onset and death: 1 hour

DUE TO

(B) Arteriosclerotic cardiovascular renal disease — 10 yrs.?

DUE TO

(C) Generalized Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October, 1946 *to* Sept 27, 1949 *that I last saw the deceased alive on* Sept. 27, 1949, *and that death occurred at* 4.45 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Allen M. D. | 6217 Harford Rd | 9/28/49 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-30-49 | Emmanuel Cem. | Calvert Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | [illegible] | Leonard J. Luck | 5305 Harford Rd. |

131a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr. Bevans
436 E. Fort Ave.

G78490

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78490

1. NAME OF DECEASED (Type or Print): Edna Owens-Dwinski
2. DATE OF DEATH: Sept. 27-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 434 E. Fort Ave.
D. STREET ADDRESS (If rural, give location) 434 E. Fort Ave
c. Length of stay in Baltimore: Yrs. Mos. Days 24-0-0

| 6. SEX | 7. COLOR OR RACE | 8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Nov. 15-1910 | 38 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Baltimore Md. | |

13. FATHER'S NAME: George N. Brewer
14. MOTHER'S MAIDEN NAME: Bertha Schwartz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Benny Owens | 434 E. Fort. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 7 Feb 1948

DUE TO

(B) Carcinoma of Sigmoid

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 7 Feb 1948 | Inoperable malignancy of sigmoid | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 22, 1949, to Sept 27, 1949, *that I last saw the deceased alive on* Sept 26, 1949, *and that death occurred at* 7.15 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr S L Bevans M. D. | 436 E. Fort Ave Balto | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-30-49 | Cedar Hill | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Leonard J. Luck - 5305 | Harford Rd. |

VS 150

46E

Clerk's age is especially important. Physicians: please write the causes of death in plain English.

G78491

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Reg'd. G78491 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma J. Marsh

2. DATE OF DEATH: Sept. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1921 Forest Park Ave.,

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2 C 3
D. STREET ADDRESS (If rural, give location): 1921 Forest Park Ave.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 4, 1885 1865 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House-work | At Home | Pa. | |

13. FATHER'S NAME: Emanuel Kauffmann

14. MOTHER'S MAIDEN NAME: Malinda Diehl

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT: MRS. MASON H. KORNMANN — ADDRESS: 430 S. AUGUSTA

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO

(B) Coronary Thrombosis — 4 days

DUE TO

(C) Chronic rheumatic endocarditis — 15 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis with hypertension ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 4, 1944, *to* Sept. 26, 1949, *that I last saw the deceased alive on* Sept. 26, 1949, *and that death occurred at* 11:30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maurice L. Shames M.D. | 3300 N. Charles St. | 9/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-29-49 | Druid Ridge | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | G. Howard Strong 3207 W. North Ave., |

VS 150

927

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78492 G78492

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 44

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret S. Moore
2. DATE OF DEATH: 9/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 220 N. Carey St.
C. Length of stay in Baltimore: 60 yrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 220 N. Carey St. 19 0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | colored | Widowed | Aug. 19. 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto. co. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Geo. S. Nelson | Sarah Smith |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | None | Blanche Hinckley 220 N. Carey St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Uremia | 2 Days |
| DUE TO (B) | Chr. Cardio-Renal Vascular Disease - Hypertension | 2 yrs. |
| DUE TO (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 21, 1949 *to* Sept. 26, 1949 *that I last saw the deceased alive on* Sept. 26, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. L. Ray Berry M. D. | 1420 E. Chase | Sept. 27 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Mt. Auburn | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| SEP 28 1949 | Huntington Williams M.D. | William I. Chatman - 1701 McCulloh St. |

VS 150

121a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78493

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

G78493

BIRTH NO. _____ Registered No. _____

1. NAME OF DECEASED (Type or Print) James Williams Masters

2. DATE OF DEATH Sept 25 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1220 Fremont Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1220 Fremont Ave

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Md 16-01
D. STREET ADDRESS (If rural, give location) 1220 Fremont ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | M | 9/9/1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Camden N. J. | U. S. A. |

13. FATHER'S NAME John Masters

14. MOTHER'S MAIDEN NAME unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Elder Masters | 1220 Fremont Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 Mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Right Inguinal Hernia

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7-25, 1949 *to* 9-25, 1949 *that I last saw the deceased alive on* 9-24, 1949, *and that death occurred at* 8:00 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Bramble Culbreth M. D. | 1543 Penna Ave | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/29/49 | St Peters Cem. | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Chas. H. Kelson | 1305 Gwynns Falls Pkwy |

937

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78:94

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 G78:94 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM SALISBURY Jr

2. DATE OF DEATH: September 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1707 E. Baltimore St. 2-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | April 10 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | B&O Railroad | Baltimore | U.S.A. |

13. FATHER'S NAME: William Salisbury

14. MOTHER'S MAIDEN NAME: Augusta Byer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No ---- | 218-03-8249 | Dorothy Salisbury 1707 E Balto. St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☒ / MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Sept. 27, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Sept 30 1949 | Holy Redeemer Cemetery | 4430 Belair Rd | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Huntington Williams, M.D. | Oppel Bros. | 1800 E Lombard St. |

VS 151

3247 937

G78495 BALTIMORE CITY HEALTH DEPARTMENT G78495

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET MULLEN

2. DATE OF DEATH: 9/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4203 Springdale avenue
c. Length of stay in Baltimore: 60 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4301 Roland avenue 27-14

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | single | June 18, 1873 | 76 | | |

10A. USUAL OCCUPATION (Give kind of work, done during most of working life, even if retired): Executive Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: Hotels Lord Balto.
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Darby Mullen
14. MOTHER'S MAIDEN NAME: Margaret Byrne
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 216-05-0838
17. INFORMANT: Mr. Mullen Walton ADDRESS: 133 Newburg ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Lung
DUE TO
Both lungs involved

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) Myocarditis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Sept 26, 1949 *that I last saw the deceased alive on* Sept 25, 1949, *and that death occurred at* 3.30 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Kadis M. D.
23B. ADDRESS: 2306 Eutaw Pl Baltimore, Md
23C. DATE SIGNED: 9-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/29/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): BALT. MD.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Chas. G. Evans & Son Inc.
ADDRESS: 118 N. Mt. Royal Ave

VS 150
156 87 Huntington Williams, MD

Please write the cause of death clearly and legibly. Physician: Correct age is especially important.

G78496

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78496 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM FOOTE

2. DATE OF DEATH: September 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 500 W. Biddle Street 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | ? | 70 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: LABORER ODD JOBS
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Adolphus Halstead ADDRESS: Cedar Hill

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 9-27-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-30-49 | Mt. Calvary Cemetery | Cedar Hill Md. |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. A. Jackson ADDRESS: 916 Penna Ave.

SW-151

PLEASE WRITE PLAINLY with pencil or pen, using ink. Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

935

G78497

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78497 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Douglas Williams

2. DATE OF DEATH: Sept. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Brady 2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Co 17-0
D. STREET ADDRESS (If rural, give location) 537 W. Lanvale St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | Colored | | 2-6-99 | 50 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer work | | Md | |

13. FATHER'S NAME: John Williams

14. MOTHER'S MAIDEN NAME: Grace Nelson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ca of Rectum spread to Bladder — 6-9 mos

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 5/21/49 | TU biopsy of Prostate revealed Ca of Rectum | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/3, 19[illegible] *to* 9/26, 19[illegible], *that I last saw the deceased alive on* 9/26, 19[illegible], *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William P. Herbst M. D. | JOHNS HOPKINS HOSPITAL | 9/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept. 29, 1949 | Arbutus Memorial Pk. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 28 1949 | Emerson Williams, M.D. | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

46D

Please write clearly with ink. Use only black or blue-black ink. Do not use pencil. Be sure your answer to each item is complete and correct as space will permit. Do not abbreviate. Write out the full name of any city, county, hospital or institution. The date of birth and age must be consistent. Be sure the cause of death is stated clearly and legibly. Items 18, 19, 21 and 22 are especially important. Physician: please write the cause of death clearly and legibly.

G78498

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78498
Registered No.

BIRTH NO. B.C. 49-20778

1. NAME OF DECEASED (Type or Print) BARBARA ANN SMITHSON

2. DATE OF DEATH Sept. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bel Air
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | 9/28/49 | | | 4 / 3 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME KENNETH PHILLIPS SMITHSON

14. MOTHER'S MAIDEN NAME ELIZABETH JEAN NAGEL

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bilateral Atelectasis | 4 hrs. 3 min. |
| | DUE TO (B) Premature Separation of Placenta | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 28, 1949, *to* Sept. 28, 1949 *that I last saw the deceased alive on* Sept. 28, 1949, *and that death occurred at* 7⁵³ A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Daniel Lewis Silverstein M. D. | West Baltimore Gen. Hosp. | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 29-49 | Cemetery | Forest Hill Memorial Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 28 1949 | Evelyn Williams, M.D. | Morton E. Kirk & Son | Jarrettsville |

160C

PLEASE WRITE PLAINLY, WITH UNFA... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78499

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1 57

G78499

Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM THOMAS ROSS

2. DATE OF DEATH Sept. 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-01

D. STREET ADDRESS (If rural, give location) 2036 E. Pratt St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Divorced | 6/14/89 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OS

10B. KIND OF BUSINESS OR INDUSTRY Seafarer

11. BIRTHPLACE (State or foreign country) Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Ross

14. MOTHER'S MAIDEN NAME Sarah Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 282-03-5640

17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of the head of the pancreas; Unknown | |
| DUE TO | invasion of liver, abdominal muscles and skin | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 16, 1949 *to* Sept. 28, 1949, *that I last saw the deceased alive on* Sept. 28, 1949, *and that death occurred at* 1:37A m., *from the causes and on the date stated above.*

23A. SIGNATURE John L. Wilson, Medical Director, M. D.

23B. ADDRESS US Marine Hospital, Balto, Md.

23C. DATE SIGNED 9/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 10/1/49

24C. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR SEP 29 1949

REGISTRAR'S SIGNATURE Tunstington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Wm. Cook, Inc., 1217 St. Paul Street

VS 150

PLEASE WRITE PLAINLY WITH UNFADING INK AND ENCLOSE ... Street age is especially important. Physicians: please write the cause of death clearly and legibly.

469

G78500 - 132067

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

430 G78500 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eugene Erhard

2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 4 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 5-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 726 E. Baltimore St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Div. | Sept. 25 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| COOK | RESTAURANT | Pa. | |

13. FATHER'S NAME: Richard Erhard

14. MOTHER'S MAIDEN NAME: Eliz. Mayes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | B. C. H. Records, 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Insufficiency

DUE TO Subacute bacterial endocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 22, 1949, *to* Sept. 27, 1949 *that I last saw the deceased alive on* Sept. 27 1949, *and that death occurred at* 8.15 am *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Ave. | 9-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | St. Peters | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| SEP 29 1949 | Huntington Williams, M.D. | Wm Cook Inc. 1217 St. Paul St. |

VS 150

72071

91a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Correct age is especially important. Physician: please write the causes of death clearly and legibly.

G78501

BALTIMORE CITY DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

G78501

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) Custom Chester B. Sears

2. DATE OF DEATH 9-27-49

3. PLACE OF DEATH
A. Baltimore City, Maryland 435 N. Exeter St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore - Maryland
D. STREET ADDRESS (If rural, give location) 435 N. Exeter Street

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W. | Married | July 18, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | Balto City Highway | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Buardgarde Sears | Lellie B. ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Mrs Rose Sears | 435 N Exeter St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis. | 1 year |
| DUE TO (B) | Arteriosclerotic Heart Disease. | ? |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Portal Cirrhosis of the Liver | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Aug 1, 1949 | Cirrhosis of the liver | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 14 19 49, to Sept 27, 19 49 *that I last saw the deceased alive on* Sept 27, 19 49, *and that death occurred at* 8:30 A. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert J. Shuckel M. D. | 2302 Edmondson Ave | Sept 28 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9-30-49 | Cedar Hill | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Huntington Williams, M.D. | William Cook & Son | 1417 St Paul |

VS 150

1248

G78502

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

80

Registered No. G78502

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): **Esther Rose Weisblatt**

2. DATE OF DEATH: **Sept. 28, 1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **1701 Ellamont St.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **1701 Ellamont St.**
C. Length of stay in Baltimore: Yrs. **45 Years** Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Maryland**
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore** 15-10
D. STREET ADDRESS (If rural, give location): **4013 Cold Spring Lane**

5. SEX: **Female**
6. COLOR OR RACE: **White**
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): **Widow**
8. DATE OF BIRTH: **July 1878**
9. AGE (In years last birthday): **71** If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Housewife**
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): **Russia**
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME: **Unkown**
14. MOTHER'S MAIDEN NAME: **Unkown**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: **Harry Weisblatt** ADDRESS: **4013 Cold Spring Lane**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchopneumonia | 2 days |
| DUE TO | metastatic cancer of | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | lungs and liver | 5 months |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Hypernephroma of right kidney. Left hypernephroma | 1931. |

19A. DATE OF OPERATION: 1931
19B. MAJOR FINDINGS OF OPERATION: Left kidney removed. Hard hypernephroma 1931
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/5, 19[illegible], *to* 9/28, 19[illegible], *that I last saw the deceased alive on* 9/28, 19[illegible], *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M.D.
23B. ADDRESS: 1324 Eutaw St
23C. DATE SIGNED: 9/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): **Burial**
24B. DATE: **9/29/49**
24C. NAME OF CEMETERY OR CREMATORY: **Beth Tfiloh Cemetery**
24D. LOCATION (City, town, or county) (State): **Windsor Mill Rd.**

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: **S. Levinson & Bros.** ADDRESS: **1124 W. NORTH AVE.**

VS 150

52a

G78503

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78503

1. NAME OF DECEASED (Type or Print): Williams, Max

2. DATE OF DEATH: 9-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 5002 Pimlico Road

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Mar 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer
10B. KIND OF BUSINESS OR INDUSTRY: SELF
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Emanuel
14. MOTHER'S MAIDEN NAME: Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Annie Williams ADDRESS 5002 Pimlico Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency
DUE TO
(B) A. S. H. D., Uremia, Bronchostasis and
DUE TO
(C) B. P. N.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-5-49, 1949, to 9-28, 1949, *that I last saw the deceased alive on* 9/28, 1949, *and that death occurred at* 9:35 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Kel M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 9/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-29-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Cem
24D. LOCATION (City, town, or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

15661 (Rev.)

93D

CERTIFICATE CORRECTED 10-6-49

Carey

G78504

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

55

Registered No. G78504

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Roswell Carey

2. DATE OF DEATH: Sept. 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-06
D. STREET ADDRESS (If rural, give location): 2718 Frederick Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write): Widowed Married
8. DATE OF BIRTH: 5-17-1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months 4, Days 29 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Retired.

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Carey

14. MOTHER'S MAIDEN NAME: Catherine Frost

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: ?

17. INFORMANT: Lawrence Carey
ADDRESS: Baltimore, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Confluent Lobular Pneumonia.

DUE TO

(B) Acute Heart failure.

DUE TO

(C) Cholangio carcinoma.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9-14-49.
19B. MAJOR FINDINGS OF OPERATION: Cholangio carcinoma
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10, 1949 *to* 9-27, 1949 *that I last saw the deceased alive on* 9-27, 1949 *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chelum T. Hall Jr. M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 9-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-30-49
24C. NAME OF CEMETERY OR CREMATORY: Mendowridge Park
24D. LOCATION (City, town, or county) (State): Dorsey Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. C. Keyser
ADDRESS: Ellicott City Md

VS 150

46F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78505

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78505

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mamie Ruckert Nutter

2. DATE OF DEATH: Sept. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1704 Binder Court

25-16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Home Work | Pa. | |

13. FATHER'S NAME: Wheatley Ruckert

14. MOTHER'S MAIDEN NAME: Fannie Harris

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Viola Wright | 508. Mc. Mehen |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquest) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Sept. 28, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/1/49 | Mt. Calvary Cem. | F. & Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Metropolitan Funeral Home Inc. 927. Mt. Ave

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G78506

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78506

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LUCY GROSS

2. DATE OF DEATH: 9-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 824 LEMON ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 18-02
D. STREET ADDRESS (If rural, give location): 824 LEMON ST.

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | C | MARRIED | 8-27-1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | — | BALTO. MD. | U. S. A |

13. FATHER'S NAME: Charles H. MASON

14. MOTHER'S MAIDEN NAME: UNKNOWN

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Joseph A. GROSS | 824 LEMON ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — (INTERVAL BETWEEN ONSET AND DEATH) 1 yr.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/15/49, to 9/28/49, *that I last saw the deceased alive on* 9/26/49, *and that death occurred at* 7:50 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fred Lewis M.D. | 450 W. Biddle St | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-1-49 | Mt. Auburn Cemetery | Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Huntington Williams, MD | William A. Jackson | 916 Fawn Ave. |

VS 150

931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78507

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

, 91 Registered No. G78507

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct as is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Thomas O. Yewell

2. DATE OF DEATH: 9/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — I737 Jackson Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04
D. STREET ADDRESS (If rural, give location): I737 Jackson Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 7/I7/I873 | 76 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Balto. Cop. Paint Co.

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Yewell - Md.

14. MOTHER'S MAIDEN NAME: Elizabeth Slamaker - Md.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Family - Same ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Squamous Cell Epithelioma — 3 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sep 12, 1949 *to* Sep 25, 1949, *that I last saw the deceased alive on* Sep 25, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alfred Cole M. D.

23B. ADDRESS: 1934 Wilkens Ave.

23C. DATE SIGNED: Sep 25 49

24A. BURIAL, CREMATION, REMOVAL (Specify): B

24B. DATE: 9/29/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

24D. LOCATION (City, town, or county) (State): Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Thomas L. McCarthy ADDRESS: I30 E. Fort Ave.

VS 150

988 15

53

G78508

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G78508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Jennie L. Beasley

2. DATE OF DEATH: Sept 28 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Methodist Home for Aged

C. Length of stay in Baltimore: 29 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-15
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov 5, 1872
AGE (In years last birthday): 76
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ga.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Beasley
14. MOTHER'S MAIDEN NAME: Sallie Leslie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Ralph Neville
ADDRESS: 107 Edgevale Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 Months
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C)

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1, 1949, *to* Sept 27, 1949, *that I last saw the deceased alive on* Sept 27, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur J Davies M. D.
23B. ADDRESS: 800 W 33rd St
23C. DATE SIGNED: Sept 28-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Sept 29/49
24C. NAME OF CEMETERY OR CREMATORY: Hillview
24D. LOCATION (City, town, or county) (State): La Grange Ga.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Frank E. Ashenworth
ADDRESS: 1615-17 Christmont Ave

VS 150

46 B

G78509

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

146

G78509

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Accuracy in correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): W. Brewer Joyce

2. DATE OF DEATH: Sept 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-11
D. STREET ADDRESS (If rural, give location): 307 Wendover Rd

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6-25-889
9. AGE (In years last birthday): 60
If Under 1 Year: Months 3, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10B. KIND OF BUSINESS OR INDUSTRY: Manager
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry B
14. MOTHER'S MAIDEN NAME: Ora Nash

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): 1st. World War
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Arteriolar Nephrosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CA of prostate c metastasis, early

INTERVAL BETWEEN ONSET AND DEATH
(A) ?
(B)
(C) ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/14 1949 *to* 9/27 1949 *that I last saw the deceased alive on* 9/27 1949 *and that death occurred at* 4:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert J. Lenckos M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 9/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Sept. 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Frd. Ave. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: John O. Mitchell Sons 1900 Eutaw Place

VS 150

156 80

51C

G78510

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): AGNES LOUISE BARRETT

2. DATE OF DEATH: Sept. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md GENERAL HOSPITAL
C. Length of stay in Baltimore: Yrs. 14 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY ANNE ARUNDEL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Linthicum Heights
D. STREET ADDRESS (If rural, give location): 203 E. Greenwood Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | --- About | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | ------ | Baltimore, Md. | |

13. FATHER'S NAME: Henry Herbes

14. MOTHER'S MAIDEN NAME: Mary Frantz

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. E. J. Brown Linthicum Hgts. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma - Bladder

DUE TO (B) & Secondary Metastasis to liver, intraperitoneum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 8/16/49 | Carcinoma Bladder | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/15, 1949 *to* 9/27, 1949 *that I last saw the deceased alive on* 9/27, 1949, *and that death occurred at* 10 PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ernest A. Cavarano M.D. | Md Gen'l Hospital | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Druid Ridge | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Carrington Williams, M.D. | C. O. Meakes and Son | 703 N. Calvert St. |

VS 150

52 C

078511

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

150 078511

BIRTH NO B.C. 49-20736 Registered No.

1. NAME OF DECEASED (Type or Print) Baby Boy Condon

2. DATE OF DEATH 9/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-6

D. STREET ADDRESS (If rural, give location) 1917 E. Lafayette

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | single | 9/28/49 | | | Natborn |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Coy Harrison Condon

14. MOTHER'S MAIDEN NAME Margaret Rock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Elinor Wolf, 1902 Augusta Ave.,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anencephaly DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/26/49 19 *to* 9/28/49 19 *, that I last saw the deceased alive on* 9/26/49 19 *, and that death occurred at* 9:53 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Leo N. Eastman M.D.

23B. ADDRESS C/o Sinai Hosp.

23C. DATE SIGNED 9/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 9/29/49

24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cem.

24D. LOCATION (City, town, or county) (State) German Hill Rd., Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR SEP 29 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

157c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78:5:12 ✓ E 916 7 G78:5:12

M. 119259

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): [redacted]. Wartus Jacobs N-946.2

2. DATE OF DEATH: Sept. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-02
D. STREET ADDRESS (If rural, give location): [redacted] 2910 Oak Hill Av.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | [redacted] 2/3/1889 | 60 [redacted] ? | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Maryland (Baltimore) | |

13. FATHER'S NAME: James A. Jacobs (DEC)

14. MOTHER'S MAIDEN NAME: Elizabeth Burns (DEC)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | B.C.H. Records | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Extensive Second & Third Degree Burns

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

CERTIFICATION APPROVED BY
FOR J. R. DAVIS, M.D., per
B S Fisher M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Infirmary Building | Infirmary Building, Baltimore City Hosp. 26/12 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 9- 26- 49 Am. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | While lighting a cigarette Pt's clothes caught on fire |

22. *I hereby certify that I attended the deceased from* 4-28-48, 19__, *to* 9-27-, 19 49 *that I last saw the deceased alive on* 9-27, 19 49, *and that death occurred at* 7.10 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Ave. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | New Cathedral Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Everington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

TO BE APPROVED BY THE MEDICAL EXAMINER.

181

G78513

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

570.5 G78513 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary R. Norris Copes

2. DATE OF DEATH: 9/27/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: Yrs. Unknown Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 510 E. North Avenue

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12/10/1868
9. AGE (In years last birthday): 80 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland (Baltimore)
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Norris
14. MOTHER'S MAIDEN NAME: Lydia Dutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: No

17. INFORMANT: Rev. Thomas Copes
ADDRESS: 510 E. North Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis, pneumonia
DUE TO Surgery for
(B) Intestinal OBstruction
DUE TO
(C) Adhesions

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9/26/49
19B. MAJOR FINDINGS OF OPERATION: Intestinal Obstruction
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/25, 19 49 *to* 9/27, 19 49 *that I last saw the deceased alive on* 9/27, 19 49 *and that death occurred at* 9.15 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ernest A. Graham M. D.
23B. ADDRESS: Md. Gen'l Hospital.
23C. DATE SIGNED: 9/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/30/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

122R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78514 — BALTIMORE CITY HEALTH DEPARTMENT — G78514

# CERTIFICATE OF DEATH

(DONELSON)

BIRTH NO. — Registered No. 17°

1. NAME OF DECEASED (Type or Print): MARGUERITE JAMES DONELSON
2. DATE OF DEATH: Sept. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3018 Oak Hill Avenue
C. Length of stay in Baltimore: 55 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7, 28-02
D. STREET ADDRESS (If rural, give location): 3018 Oak Hill Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Oct. 19 1893 | 55 | 11 9 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Office Work | Milk Industry | Maryland (Balto.) | U.S. |

13. FATHER'S NAME: Mitchell James
14. MOTHER'S MAIDEN NAME: Mary (Unknown)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mr. Frank Donelson | 3018 Oak Hill Ave. 7 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of the Breast | 2 years + |
| DUE TO (B) | | |
| DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| August 1947 | Carcinoma of the Breast | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb. 25, 1949 *to* Sept 28, 1949 *that I last saw the deceased alive on* Feb. 28, 1949 *and that death occurred at* 7:35 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Millard T. Tealord Jr. M. D. | 3400 Woodbine Ave. 7 | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Entombment | 9/30/49 | Lorraine Maus. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as far as known. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G78515

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G 78515

Registered No. G 78515

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bessie Hawkins

2. DATE OF DEATH: Sept. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 540 Burgundy Street
c. Length of stay in Baltimore: Yrs. - Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 540 Burgundy St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | married | Jan.15,1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | - | A.A.Co., Maryland | |

13. FATHER'S NAME: James Garrett

14. MOTHER'S MAIDEN NAME: Margaret Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| - | - | Samuel Smith-6764 Cherry Hill Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Resp. failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic glomerulo-nephritis

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-21- , 1949, *to* 9-27- , 1949, *that I last saw the deceased alive on* 9-27- , 1949 *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Sborofsky M. D. M. D. | 607 N. Howard St. | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-1-49 | Mt. Calvery | A.A.Co., Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 9-29-49 | Huntington Williams, M.D. | Walter B. Sprigg 139 W. Hamburg St. 131 B |

VS 150

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

BIRTH NO. G78516

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78516

1. NAME OF DECEASED (Type or Print): Elizabeth Crenshaw

2. DATE OF DEATH: Sept. 27.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Avenue
c. Length of stay in Baltimore 31 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-E
D. STREET ADDRESS (If rural, give location): 805 North Dallas Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Femal | Col. | Married | Oct. 9. 1896 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Kinston N.C. | U.S.A. |

13. FATHER'S NAME: Alfert Jarman

14. MOTHER'S MAIDEN NAME: Nicey Whalen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | James Jarman | 1916 E. Chase Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive - Cardio Vascular

DUE TO

(B) Renal Disease — 6 mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1st, 1949 *to* September 27, 1949, *that I last saw the deceased alive on* 9-26-, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. L. Jackson M. D. | 600 N. Arlington Ave. | 9-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 1.49 | Mt Calvery Cem. | Brooklyn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Huntington Williams, M.D. | Elroy C. Wilson | 1000 Brantly Avenue |

VS 150

PLEASE WRITE PLAINLY WITH UNFADING INK. Entries must be complete and correct as possible. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

121a

G78517 ✓ SEP 29 1949 G78517

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. 754 Registered No.

1. NAME OF DECEASED (Type or Print): Rosalie Martin

2. DATE OF DEATH: Sept. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Allegany
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westernport
D. STREET ADDRESS (If rural, give location): Box 312

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | | Dec. 5, 1948 | | 9 / 23 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | U.S.A. |

13. FATHER'S NAME: William H. Martin

14. MOTHER'S MAIDEN NAME: Lola McClarke

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sep 22, 1949 *to* Sep 28, 1949, *that I last saw the deceased alive on* Sep 28, 1949, *and that death occurred at* 10 51 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Green, Jr. M. D. | Union Memorial Hosp. | 9-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/1/49 | Oakhill Cem | Lonaconing Md |

| FILED RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 29 1949 | Curington Williams M.D. | R. H. C. & B. M. Walton | Oakland Md |

VS 150

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Please write the correct age is especially important.

G78518

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 443 Registered No. G78518

1. NAME OF DECEASED (Type or Print): William T. Crandell

2. DATE OF DEATH: 9/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 23rd
D. STREET ADDRESS (If rural, give location): 346 S. Stricker St.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 1/2/1879
9. AGE (Last birthday): 70 yrs. If under 1 Year: Months Days. If under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Crandell
14. MOTHER'S MAIDEN NAME: Rebecca Chamberlain
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 218-09-8653
17. INFORMANT: William W. Crandell ADDRESS: 346 S. Stricker St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral hemorrhage, left — 3 days

DUE TO

(C) Arteriosclerotic Hypertensive CVD

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/24, 1949 *to* 9/27, 1949, *that I last saw the deceased alive on* 9/27, 1949, *and that death occurred at* 3:30 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert L. Erickson, M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 9/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9/30/49
24C. NAME OF CEMETERY OR CREMATORY: St James Cem
24D. LOCATION (City, town or county) (State): Deale Md
25. FUNERAL DIRECTOR: Robt C. & B. M. Watkins Streets

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

VS 150

92D

G78519 ✓ G78519

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 17838

BIRTH NO. B.C. 49-20467

1. NAME OF DECEASED (Type or Print): Baby Girl Newby

2. DATE OF DEATH: Sept 24, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
c. Length of stay in Baltimore: 6 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: (If outside corporate limits, write RURAL and give township) Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 917 S. Shanys St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored. | Single | 9/23/49 | | — | 3 | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | None | Md. | U.S.A. |

13. FATHER'S NAME: Robert Hall

14. MOTHER'S MAIDEN NAME: Virgie Newby 917 Shanys St

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | No. | None. | Mother. | 917 S. Shanys St. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO: Prematurity c pemphigus with injury resulting in cerebral hemorrhage. | 3 days. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/23, 1949, to 9/26, 1949, *that I last saw the deceased alive on* 9/26, 1949, *and that death occurred at* 7:30 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. C. Abraham M.D. M.D. | Provident Hosp. | 9/26/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) ADDRESS |
|---|---|---|---|
| Burial | 9/29/49 | Mt Calvary | A.A. Co., Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| SEP 29 1949 | Hunter Williams, M.D. | J.L. Brown & Son 101 W Montgomery St |

VS 150

160a

Please write plainly with ink. Fill out every item. Be sure to state correct age in years, months, days or hours. Physicians: please write the causes of death clearly and legibly. Especially important.

G78520

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78520

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Agnes George Mason

2. DATE OF DEATH: Sep-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01
D. STREET ADDRESS (If rural, give location): 1532 W Lafayette

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Apr 8-1897
9. AGE (In years last birthday): 52 yrs (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: C. H. Carter George
14. MOTHER'S MAIDEN NAME: Louise Dugan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Louise D George (mother) ADDRESS: Balto.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma, oesophagus — INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) —
DUE TO —
(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: July 8th 1949
19B. MAJOR FINDINGS OF OPERATION: Biopsy of oesophagus revealed squamous carcinoma
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June 23d, 1949, to September 28th, 1949, that I last saw the deceased alive on September 27, 1949, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE: J. E. Ulstad M. D.
23B. ADDRESS: 1200 N. Calvert St.
23C. DATE SIGNED: 9-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 9-30-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lucian Moore Co.
ADDRESS: Balto.

VS 150

46a

PLEASE WRITE PLAINLY WITH PEN OR PENCIL. DO NOT USE ABBREVIATIONS. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 3-10-50 ✓ X

G78521 W-340 Talbot

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50 G78521 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William (Whitely) (Jr.) WHITELEY SR.

2. DATE OF DEATH 9/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. Towson
D. STREET ADDRESS (If rural, give location) Virginia Ave., Towson

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Aug. 1, 1876 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | none | Balto. Md. | USA. |

13. FATHER'S NAME WHITELEY William (Whitely) SR.

14. MOTHER'S MAIDEN NAME Fannie Potts

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Unknown | no | no | Daughter | See Above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of esophagus — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/28/49 | Carcinoma esophagus | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/28, 1949, *to* 9/29, 1949, *that I last saw the deceased alive on* 9/29, 1949, *and that death occurred at* 5:20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas W. Mays M. D. | Mercy Hosp. | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Loudon Park | Stewart Morris |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 23 1949 | Hamilton Williams, M.D. | | Balto Md |

VS. 1961949

46a

Please write clearly and legibly. Physicians: please write the causes of death clearly and correct age is especially important.

078522

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

33 Registered No. 078522

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HERMAN KOSLOWSKI

2. DATE OF DEATH: Sept. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2563 FREDERICK AVE
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-05
D. STREET ADDRESS (If rural, give location): 2563 FREDERICK AVE.

5. SEX: MALE
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Sept. 29, 1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FOREMAN
10B. KIND OF BUSINESS OR INDUSTRY: City Water Dept
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FERDINAND KOSLOWSKI
14. MOTHER'S MAIDEN NAME: CAROLINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: Annie M. KoslowsKi ADDRESS: 2563 Frederick

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO
ANTECEDENT CAUSES
(B) Arterio Sclerosis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cardiac Hypertrophy

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1948 to June, 1949 that I last saw the deceased alive on Sept 10, 1949 and that death occurred at 7:00 A m., from the causes and on the date stated above.

23A. SIGNATURE: M. Chodecki M.D.
23B. ADDRESS: 2725 Linden
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-3-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George L. Schwab ADDRESS: 2101 Frederick Ave.

VS 150

95c

Please write clearly with ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

678323 ✓ v. 1 678323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert F. Laupp

2. DATE OF DEATH: Sept. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4611 Asbury Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4611 Asbury Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 30, 1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| interior Decorator | J. Holland Williams | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Laupp | Elizabeth Arnold |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY # | 17. INFORMANT — ADDRESS |
|---|---|---|
| no | 217-17-3685 | Mrs. Eutha E. Laupp, 4611 Asbury Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 10, 1949, *to* Sept 29, 1949, *that I last saw the deceased alive on* Sept 28, 1949, *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Russel Brooke, M.D. | 133 Druid Park Drive | 9-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/1/49 | Meadow Ridge Park | Elkridge Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

VS 150

93 D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78524

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78524

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Svach, Flora (Svach)

2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore

c. Length of stay in Baltimore: Yrs. life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: [illegible]
2036 Hunter St., [illegible], Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 2038 E. Lanvale St. 8-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | 1/12/1929 | 20 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Edgar Stockett
14. MOTHER'S MAIDEN NAME: Catherine Alard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Joseph Svach
ADDRESS: same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia
DUE TO
(B) Tuberculous meningitis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-3 1949 *to* [illegible], 19[illegible], *that I last saw the deceased alive on* 9-24 1949 *and that death occurred at* 11:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Vital M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 9-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/1/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc
ADDRESS: Balto.

VS 150

14

Please write clearly and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78525

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

760.0

G78525 Registered No.

BIRTH NO. B.C. 49-20656

1. NAME OF DECEASED (Type or Print): Baby Boy Bromiley

2. DATE OF DEATH: September 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

C. Length of stay in Baltimore: 6 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 24 North Broadway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | S | September 19, 1949 | | | 6 | 4 | 34 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: B. Roy Bromiley

14. MOTHER'S MAIDEN NAME: Justine Gilkay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 North Broadway

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intracranial hemorrhage — 6 day 4 hours

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Subcapsular hemorrhage, liver

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* September 19 19 49 *to* Sept. 25, 19 49 *that I last saw the deceased alive on* Sept. 25, 19 49 *and that death occurred at* 1:46 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George W. Corner Jr. M. D. | 601 North Broadway | 9-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Holy Redeemer | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | | |

VS 150

160a

Please write clearly and legibly. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G78526

JL - 132174

BIRTH NO. 49-21957

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78526

1. NAME OF DECEASED (Type or Print): Baby Boy Williams- Doris

2. DATE OF DEATH: 9-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals

C. Length of stay in Baltimore: 3 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 823 N. Fremont Ave.

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 27, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.: 2

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clarence Henry
14. MOTHER'S MAIDEN NAME: Doris Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [ ] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 27, 1949 *to* Sept. 27, 1949 *that I last saw the deceased alive on* Sept. 27, 1949 *and that death occurred at* 6:30 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Hogan M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 9-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 9-28-49
24C. NAME OF CEMETERY OR CREMATORY: B.C.H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

Please write the cause of death clearly and legibly. Correct age is especially important. Physicians:

G78:527

JL - 132145

BIRTH NO. BC 49-20513

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

176

Registered No. G78:527

1. NAME OF DECEASED (Type or Print): Baby Boy Davis - ~~Jones~~

2. DATE OF DEATH: Sept. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 3 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 118 N. Green St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Sept. 26, 1949 | | | 1 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Davis
14. MOTHER'S MAIDEN NAME: Joyce Boston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: B. C. H. Records. ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Prematurity | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 26, 1949 *to* Sept 26, 1949, *that I last saw the deceased alive on* Sept. 26, 1949, *and that death occurred at* 3:50 PM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 9-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 9-28-49
24C. NAME OF CEMETERY OR CREMATORY: B.C.H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78528 B-131957

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

70.0 ✓ Registered No. G78528

BIRTH NO. B.C. 49-19875

1. NAME OF DECEASED (Type or Print) Todd Briscoe

2. DATE OF DEATH 9-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospitals

C. Length of stay in Baltimore 3 Days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 15-21
D. STREET ADDRESS (If rural, give location) 1613 Balmor (Baltimore) Ct.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Single | Sept. 15, 1949 | | | 3 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Paul Briscoe

14. MOTHER'S MAIDEN NAME Gertrude Christmas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS 4940 RECORDS*BALTO. CITY HOSPITALS EASTERN AVE.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia

DUE TO

(B) Pulmonary Hemorrhage

DUE TO

(C) Erythroblastosis Fetalis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [ ] NO [ ] yes

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-18, 1949, *to* 9-21, 1949 *that I last saw the deceased alive on* 9-21 1949 *and that death occurred at* 1:00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 4940 Eastern Avenue

23C. DATE SIGNED 9-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremated

24B. DATE 9-23-49

24C. NAME OF CEMETERY OR CREMATORY B. C. H. Crematory

24D. LOCATION (City, town, or county) (State) 4940 Eastern Ave. ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR SEP 30 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR

VS 150

161C

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FLOSSIE P. ROBUST ✓

G78529

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

334 Registered No. G78529

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robust, Flossie P.

2. DATE OF DEATH: September 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-08

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

D. STREET ADDRESS (If rural, give location): 1308 Union Avenue

c. Length of stay in Baltimore: 50 years (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | Feb. 16-1891 | 58 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Lohr

14. MOTHER'S MAIDEN NAME: Agnes C. Favorite

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Wilson L. Robust ADDRESS: 1308 Union Ave.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: one month

DUE TO

ANTECEDENT CAUSES

(B) Ruptured Cerebral Aneurysm

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive cardiovascular disease — year

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8-27, 1949 *to* 9-28, 1949, *that I last saw the deceased alive on* 9-28, 1949, *and that death occurred at* 12 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marvin D. Davis M.D. | Vet Balto Gen Hosp | 9-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | ADDRESS |
|---|---|---|---|---|
| Burial | Sept. 30-1949 | Woodlawn | Baltimore Co. Md. | |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 363 Falls Road

VS 150

96

Physicians: please write the causes of death clearly and legibly. Information is especially important. Be sure that the correct age is entered.

CERTIFICATE CORRECTED 10-19-49

G78530

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78530

BIRTH NO. G78530

1. NAME OF DECEASED (Type or Print): Anna Konopik

2. DATE OF DEATH: 9/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen Hosp.

C. Length of stay in Baltimore: 39 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-15
D. STREET ADDRESS (If rural, give location): 1512 Cypress St Curtis Bay.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | [illegible] | ? | 39 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: J. Abromaitis

14. MOTHER'S MAIDEN NAME: ANNA [illegible] ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Joseph Konopik ADDRESS: 1512 Cypress St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peripheral Vascular Collapse, etiology undet. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

(B) Rheumatic Cardio-vascular disease — Approximately 25 yrs. 5 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/28 19 49 *to* 9/28 19 49 *that I last saw the deceased alive on* 9/28 19 49 *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: West Balto Hosp

23C. DATE SIGNED: 9/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct 3-1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem

24D. LOCATION (City, town, or county) (State): Anne Arundel County

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949

REGISTRAR'S SIGNATURE: Turnington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph Kaminskas Inc. ADDRESS: 602 Washington Blvd.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

408718

G78531

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78531

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John C. Pulley

2. DATE OF DEATH: Sept. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Hal 2 - Surg

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 41 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 700 S. Hanover St. 22-01

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep
8. DATE OF BIRTH: 11-20-07
9. AGE (In years last birthday): 41 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer
10B. KIND OF BUSINESS OR INDUSTRY: Trucking Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Laurence Pulley
14. MOTHER'S MAIDEN NAME: Ruth Royal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9/22/49
19B. MAJOR FINDINGS OF OPERATION: Gangrene of entire small intestine; mesenteric thrombosis
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Neither
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-22- 1949, to 9-28- 1949 that I last saw the deceased alive on 9-24- 1949, and that death occurred at 4 0'clock P.M., from the causes and on the date stated above.

23A. SIGNATURE: Dwight C. McLean M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 9/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct-3.49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Natinoal
24D. LOCATION (City, town, or County) (State): Baltimore City

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Tunstington Williams, M.D.
25. FUNERAL DIRECTOR: Isiah L. Brown & Sons. — ADDRESS: 108 W. Montgomery

VS 150

99

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78532

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78532

1. NAME OF DECEASED (Type or Print): William J. Jackson

2. DATE OF DEATH: 9/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 24 N. Mount St

C. Length of stay in Baltimore: 40 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore, City
D. STREET ADDRESS (If rural, give location): 246 N. Mount Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 1 Day: Hours, Min. |
|---|---|---|---|---|---|---|
| M | C | Married | 1/3/1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Self Employed | Huckster | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Jackson | Lucy A. ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Emma M. Jackson | 246 N. Mount St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 1 month |
| DUE TO (B) | Congestive Heart Failure and chronic glomerulonephritis | 12 months |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 27, 1949 *to* Sept 27, 1949 *that I last saw the deceased alive on* Sept 26, 1949 *and that death occurred at* 6:50A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Washington Jr. M. D. | 13 S. W. Washington St. | Sept 29 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct-2-49 | Mt Zion Cemetery | Lansdowne Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | Isiah L. Brown & Sons | 108 W. Montgomery St. |

VS 150

1218

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78533

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143

Registered No. G78533

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EVA B. EBAUGH

2. DATE OF DEATH Sept. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenway Apts. Charles & 34th Sts.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-8
D. STREET ADDRESS (If rural, give location) Greenway Apts. Charles & 34th Sts.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | June 18, 1879 | 70 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Balto., Md. | |

13. FATHER'S NAME: Robert G. Bordley

14. MOTHER'S MAIDEN NAME: Mary V. Groff

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| - | - | Mr. Irvin Ebaugh - Old Court Rd., Pikesville |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemorrhage | |
| DUE TO | (B) Hypert. C.V. disease degeneration of myocard | 10 years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Sept 15, 1945, to Sept 27, 1949, that I last saw the deceased alive on Sept 27, 1949 and that death occurred at 1 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Kirk Heavy M.D. | 2301 Reba Pl. | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78534

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44 Registered No. G78534

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY M. MORITZ

2. DATE OF DEATH: Sept. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3122 Berkshire Rd.
c. Length of stay in Baltimore: Life (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 3122 Berkshire Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | Feb. 3, 1861 | 88 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Andrew Gernard
14. MOTHER'S MAIDEN NAME: Fredericka Fehrmann
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT (ADDRESS): Mrs. Minnie Wittig 3122 Berkshire Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Cardio-Vascular Disease | 20 years |
| DUE TO (B) | Chronic Nephritis | 53 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Arthritis | 30 years |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 20, 1949 *to* Sept. 29, 1949, *that I last saw the deceased alive on* Sept 29, 1949, *and that death occurred at* 4:00 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Roy M. Zimmerman M.D.
23B. ADDRESS: 2858 Hanford Rd.
23C. DATE SIGNED: 29 Sept. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: Sept. 30, 49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, MD.

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78535

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78535

Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA KOHLHEPP

2. DATE OF DEATH: Sept. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Nursing Home, 3605 Hillsdale Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 1128 W. Baltimore St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | April 12, 1872 | 77 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Baltimore, Md. | |

13. FATHER'S NAME: Julius -

14. MOTHER'S MAIDEN NAME: Kunnegunda Dressler

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Mrs. Lillian E. Naff - 1128 W. BaltimoreSt |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 16 days |
| DUE TO (B) | Arteriosclerosis Gen'l. | 2 yrs. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-13, 1949 *to* 9-27-, 1949, *that I last saw the deceased alive on* 9-27, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard K. Warner M.D. | 2617 Garrison Blvd | 9-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/1/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

8-2a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78536

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

56-1

Registered No. G78536

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE SMITH

2. DATE OF DEATH: Sept. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1533 Argonne Drive

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-22
D. STREET ADDRESS (If rural, give location): 1533 Argonne Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Aug. 18, 1878 | 71 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Baltimore, Md. | |

13. FATHER'S NAME: Charles H. Hoffer

14. MOTHER'S MAIDEN NAME: Katherine A. Kubichek

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | no | Miss Dora Smith | 1533 Argonne Drive |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) carcinoma of liver — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: (A) 1 year

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 2 1923 *to* Sept 28 1949, *that I last saw the deceased alive on* Sept 28, 1949, *and that death occurred at* 3 40 A. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George Dunyo M. D. | 4808 Harford Rd. | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/1/49 | Baltimore Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46F

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

178537 No. 1 678537

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE M. F. DEPFER.

2. DATE OF DEATH: Sept 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2010 Oakington Sta

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-08
D. STREET ADDRESS (If rural, give location): 2010 Oakington Sta

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Sept 6 1893
9. AGE (In years last birthday): 56 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Depfer.
14. MOTHER'S MAIDEN NAME: Laura L. Morrison.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 215-07-6596
17. INFORMANT: Laura L. Depfer ADDRESS: 2010 Oakington Sta

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Min.

DUE TO

(B) Coronary Artery Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 6, 1949 *to* Sept. 29, 1949 *that I last saw the deceased alive on* Sept 22, 1949 *and that death occurred at* 4 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edward L. Hassman M. D.
23B. ADDRESS: 407 Dulaney Rd.
23C. DATE SIGNED: 9/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 1/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park.
24D. LOCATION (City, town, or county) (State): Windsor Mill Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Lamington Williams, M.D.
25 FUNERAL DIRECTOR: Thomas E. Donovan ADDRESS: 3818 Roland Ave

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78538 ✓ G78538

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. B.C.H-3544 — Registered No. 60

1. NAME OF DECEASED (Type or Print): Richard Howie — 2. DATE OF DEATH: SEP 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-07
D. STREET ADDRESS (If rural, give location): 1602 E. Hoffman St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 10-26-45 | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | | Md | |

13. FATHER'S NAME: John Rone
14. MOTHER'S MAIDEN NAME: Annie Howie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral damage | 8 days |
| DUE TO | | |
| (B) | Cardiac arrest under anesthesia | |
| DUE TO | | |
| (C) | anesthesia given for repair of hernia + T + A. on 9-20-49 | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Heart started but cerebral damage irreparable

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-20-49 | Umbilical, L. inguinal hernia, hydrocele, ect. adenoid | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location) |
|---|---|---|
| — | — | / |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 9-19- 1949 *to* 9-29- 1949, *that I last saw the deceased alive on* 9-29- 1949, *and that death occurred at* 2:00 a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul C. Adkins, M.D. M. D. | JOHNS HOPKINS HOSPITAL | 9-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Sept 30/49 | | Salisbury N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | [illegible] M.D. | Mrs Robert A Ellis + Daughter | |

VS 150 Paul C. Adkins — 1129 N. Carlton St 122a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78539

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78539

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles White

2. DATE OF DEATH: Sept. 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Dalen 2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 1124 E. Lombard St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | Married | | 44 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home duties
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Edw. White
14. MOTHER'S MAIDEN NAME: Fernanda Nelson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Neoplasm, type undetermined of lung — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease & cardiac failure — DUE TO

(C) Paroxysmal auricular flutter — Radiation effects, general

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edyth H. Schoenrich M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 9/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 3/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A.A. County Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Irvington Matthews, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Mrs Robert G. Elliott & Son 1129 N. Carrollton St 47D

VS 150

G78540

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

49 G78540 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CONRAD DOTTERWEICH

2. DATE OF DEATH: September 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-04
D. STREET ADDRESS (If rural, give location): 122 Jackson Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | ? | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Dotterweich
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: John C. Dotterweich ADDRESS: 402 Collington Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Sept. 26, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 1 1949 | Holy Redeemer Cemetery | 4430 Belair Rd. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: SEP 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Diffel Bros. ADDRESS: 1800 E Lombard St.

108

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78541

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 3 1

G78541 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Cotton.

2. DATE OF DEATH: 4-26-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1529 W. Lexington

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1529 W. Lexington St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1529 W. Lexington St
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 19-02
D. STREET ADDRESS (If rural, give location) 1529 W. Lexington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | Widow | 6-1-1885. | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | [illegible] Co. N. C. | U.S.A. |

13. FATHER'S NAME: Biage Allen

14. MOTHER'S MAIDEN NAME: Middie A. Pulley.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mr James Cotton (son) | 1524 W. Lexington |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 months

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/15/ 19[illegible] *to* 9/26, 19[illegible] *that I last saw the deceased alive on* 9/26, 19[illegible], *and that death occurred at* 10. m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph W. Redden M.D. | 410 N. Gilmor | 9/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Sept 29 49 | Rocky Mount | North Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Lexington Williams, M.D. | Mrs Katie R. Williams | 3218 Edmondson |

VS 150

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G 8542

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G78542
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Mobley

2. DATE OF DEATH: 9-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 617W Saratoga St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 617 W. Saratoga St

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 617 W. Saratoga St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 617 W. Saratoga St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | C | Widower | 2-1-1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | | White Oak, S.C. | U.S.A. |

13. FATHER'S NAME: E.P. Mobley

14. MOTHER'S MAIDEN NAME: Annie Wilson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Lottie Mobley | 511 Seminary Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension
DUE TO
(B) Cerebral Vascular Disease
DUE TO
(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/2/49, 19__, *to* 9/28, 19 49, *that I last saw the deceased alive on* 9/25, 19 49, *and that death occurred at* 7:40 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Carnes M.D. | 32 Cornect | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sept 30 | Winnsboro | South Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 32 N Schroeder St |

VS 150

937

GM. 132070 G7852 ; 401.1 G78543

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 41

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kenneth Coates

2. DATE OF DEATH: 9- 27- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 1919 Herbert ST, Z 17.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Married | Sept. 29 1909 | 39 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MD. | |

13. FATHER'S NAME: Kemp Coates

14. MOTHER'S MAIDEN NAME: Carrie Thomas

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. 401.1

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) cardiac decompensation ~~Rheumatic Heart Disease~~

DUE TO

(B) Mitral & aortic valvular disease

DUE TO

(C) Rheumatic fever

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

over

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9- 22- , 1949, *to* 9- 27- , 1949, *that I last saw the deceased alive on* 9- 27- 1949, *and that death occurred at* 9.00 AM. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | B.C.H. 4940 Eastern Ave. | 9- 27- 49. |

| 24A. BURIAL—CREMATION REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 2 1949 | Arbutus Memorial | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | [signature] Registrar, Md. | Mrs Katie R. Williams | 3231 Edmondson Ave |

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

95B

G78544 ✓ 44 ✓ G78544

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ADAM-MURAWSKI (Moreski)

2. DATE OF DEATH: Sept. 29-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 608 S. Bethel St.

c. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 2-02
D. STREET ADDRESS (If rural, give location): 608 S. Bethel St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retiredle

10B. KIND OF BUSINESS OR INDUSTRY: Fertilizer

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Murawski

14. MOTHER'S MAIDEN NAME: ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 228-10-9436

17. INFORMANT: Alexandra Murawski ADDRESS: 608 S. Bethel St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 days.

DUE TO

(B) Arterio-Sclerotic Cardio-Renal Disease ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 23, 1949, *to* Sept 29, 1949, *that I last saw the deceased alive on* Sept 26 1949, *and that death occurred at* 7:30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Snidler, M. D.

23B. ADDRESS: 2348 Eutaw Place

23C. DATE SIGNED: Sept 30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 3-1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary

24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949

REGISTRAR'S SIGNATURE: Deputy for Millicent Mc O

25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 2007 Eastern Ave

131a

Correct age is especially important. Surname, given name, middle name, if any, should be printed plainly.

HEINZENBERGER ✓

BALTIMORE CITY HEALTH DEPARTMENT E 900 0

# CERTIFICATE OF DEATH

BIRTH NO. G78545 Registered No. G78545

1. NAME OF DECEASED (Type or Print): Mary Heinzenberger N-5 20. 0
2. DATE OF DEATH: 9-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
c. Length of stay in Baltimore: 80 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 14-01
D. STREET ADDRESS (If rural, give location): 135 Mosher St

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: April 5 1865
9. AGE (In years last birthday): 84 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Francis E. Morrison
14. MOTHER'S MAIDEN NAME: Georgeanna Gordon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mr Harry Heins ADDRESS: 135 Mosher St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Post operative irrepressible shock — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Operation nailing of femur
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
R T Frahm M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION: 9 26 49
19B. MAJOR FINDINGS OF OPERATION: Fracture neck of femur
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 135 Mosher St. 14/1
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Sept. 19, 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell down two steps at home

22. I hereby certify that I attended the deceased from 9-21 1949 to 9-28 1949, that I last saw the deceased alive on 9-28 1949 and that death occurred at 8 30 A.m., from the causes and on the date stated above.

23A. SIGNATURE: J Frederick M. D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 9-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 1/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: SEP 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Harry A. Witzke ADDRESS: 4101 Edmondson Ave

VS 150

correct age is especially important. Payments, please write the name of the deceased on the back of each check.

186a

G78546

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78546

1. NAME OF DECEASED (Type or Print): katherine E. PALANES 513068

2. DATE OF DEATH: SEP 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Halsted 6
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. 0 Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pa.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cairnbrook
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | 3-22-89 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Europe | |

13. FATHER'S NAME: Matthew Rogosky

14. MOTHER'S MAIDEN NAME: Magdelene Rogosky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Embolism | |
| DUE TO (B) | Carcinoma of Stomach | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9-22- 1949 *to* 9-30- 1949 *that I last saw the deceased alive on* 9-30- 1949 *and that death occurred at* 6 [illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irene E. Chaney M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/49 | Parish Cemetery | Catonsville, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Lenington for Williams, M.D. | Wm. J. Tschudy & Sons | Balto, Md. |

VS 150

46 B

correct age is especially important. Physicians, please write the same

G78547

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

53 G78547 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Truss

2. DATE OF DEATH: 9/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 1220 Dukeland St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | Aug 24, 1871 | 78 | 1 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Night Watchman | Household Robes | Baltimore | |

13. FATHER'S NAME: Paul Truss

14. MOTHER'S MAIDEN NAME: Katherine E. Heinert

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No No | 220-03-6348 | William H. Rossman | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Accident DUE TO | 9-21-9-28 |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | 12 Intestinal Obstruction due to Adenocarcinoma of Colon. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 9-27-49 | Adenocarcinoma of Colon. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-23-49, 19__, *to* 9-28-49, 19__, *that I last saw the deceased alive on* 9-28-49, 19__, *and that death occurred at* 12:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard Town Grant M.D. M. D. | W. G. H. Hosp. | 9-28-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-1-49 | Westview | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | Chas. H. Dole | 1913 Balto. St. |

VS 150

46 E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78548

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78548

1. NAME OF DECEASED (Type or Print): ANNA HASSE

2. DATE OF DEATH: 9-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 25-05
D. STREET ADDRESS (If rural, give location): 1344 CAMBRIA St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1344 CAMBRIA St.

C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | WIDOWED | 12/9/ | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | HOME | MARYLAND | U.S.A. |

13. FATHER'S NAME: MARTIN CAVENY

14. MOTHER'S MAIDEN NAME: JANE ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | ? | ELIZABETH REEVES | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary thrombosis | 10 minutes |
| DUE TO (B) | Arteriosclerotic cardio vascular disease & hypertension | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Sept. pneumonia | 4 years. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* Sept. 29, 1949, *that I last saw the deceased alive on* Sept. 27, 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry W. Gebert M. D. | 1700 Fanning Way Ave. | 9/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-3-49 | HOLY CROSS | BALTO. CO. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams M.D. | LILLY & ZEILER INC. | BALTO. |

VS 150

92 D

Correct age if especially important. Physicians, please write the cause of death plainly.

G78549

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

0 3

Registered No. G78549

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DAVID SINGLETON

2. DATE OF DEATH September 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
225 S. Bethel Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-01
D. STREET ADDRESS (If rural, give location) 18 S. Bond Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Single | 4/13/1908 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | S. C. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Abraham Singleton | Elizabeth Bush |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | 255-05-3504 | Annie Stewart (S.) | 225 S. Bethel |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Syphilitic aortitis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | [X] | Sept. 23, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 9/30/49 | Mt Auburn | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | Chas. S. Cooper | 512 Cathedral St. |

VS 151

20D

correct age is especially important. Physicians please write the causes of death clearly and legibly.

78550

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.L. 49-20409 CERTIFICATE OF DEATH Registered No. 78550

1. NAME OF DECEASED (Type or Print): Baby Boy Meyer

2. DATE OF DEATH: 9/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.

C. Length of stay in Baltimore: 18 hours

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 816 Jefferson St
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Md. 25-04
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 9/21/49 | | | 17 42 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant | Dependent. | Maryland | USA |

13. FATHER'S NAME: John Meyer

14. MOTHER'S MAIDEN NAME: Anna Mulholland

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Anna Meyer | 816 Jefferson |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia, neonatorum — INTERVAL BETWEEN ONSET AND DEATH: 17 hours 42'

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Premature Separation of the placenta — 17 hours 42'

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | None | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| — m. | WHILE AT WORK ☒ NOT WHILE AT WORK ☒ | — |

22. *I hereby certify that I attended the deceased from* September 21, 1949 *to* September 22 1949, *that I last saw the deceased alive on* Sept. 22, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles I. Henderson M. D. | Univ. Hospital | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | University Medical School | SEP 30 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| SEP 30 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

160C

G78551

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

G78551 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SADIE M. MARSHALL

2. DATE OF DEATH: Sept. 29, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3208 Lyndale Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
d. STREET ADDRESS (If rural, give location): 3208 Lyndale Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Jan. 17, 1885 | 64 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James P. Streett | Sallie (Unknown) |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 216-07-3759A | John W. Marshall | 3208 Lyndale Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 6 hours

DUE TO

(B) Ch. Hypertension

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 45 *to* Sept 29, 1949 *that I last saw the deceased alive on* Sept 29, 1949 *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3805 Belair Rd | Sept 30/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Meadow Ridge Memorial | Dorsey, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 1949 | Errington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

83a

G78552 ✓ 4 ✓ G78552

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marie M. Volz

2. DATE OF DEATH: Sept. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 826 Burgandy St.

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 3/26/1893 | 56 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry Heim
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Henry J. Volz ADDRESS: 826 Burgandy St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Sept. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/3/49
24C. NAME OF CEMETERY OR CREMATORY: St. Paul's
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

937 ✓

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78553

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78553

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES. AQUILA JONES

2. DATE OF DEATH 9-30-49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

b. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY BALTO. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE-11 12-07
D. STREET ADDRESS (If rural, give location) 2207 HUNTINGDON RUE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | 1-12-1863 | 86 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE, Retired
10B. KIND OF BUSINESS OR INDUSTRY NONE Pa. R.R.
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME NICHOLAS JONES
14. MOTHER'S MAIDEN NAME MARY ELIZABETH LEAF
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) UNKNOWN (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT WIFE (Margaret Jones) ADDRESS SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolus, large, rt. pulmonary artery,
DUE TO
(B) Generalized arteriosclerosis, marked,
DUE TO
(C) Benign prostatic hypertrophy
Acute cystitis, severe.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 9, 1949, to Sept. 30, 1949, *that I last saw the deceased alive on* Sept 30, 1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles H. Watt, Jr., M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 9/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/3/49
24C. NAME OF CEMETERY OR CREMATORY Curtis Bay
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 3 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Cook Inc ADDRESS 1217 St. Paul St.

VS 150

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078554 BALTIMORE CITY HEALTH DEPARTMENT 078554

BIRTH NO. B.C.-49-19921 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Swan, Donald Edward

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: 12 da. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-01
D. STREET ADDRESS (If rural, give location): 1150 Cooksey St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | Single | Sept. 19, 1949 | | 12 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore | |

13. FATHER'S NAME: Donald Edward Swan

14. MOTHER'S MAIDEN NAME: Jeannette Sabina Budinski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Dehydration & acidosis
DUE TO
(B) Acute Enteritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 29, 1949, *to* Oct. 1, 1949 *that I last saw the deceased alive on* Oct. 1, 1949 *and that death occurred at* 2:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. M. Kaan M. D.

23B. ADDRESS: 1400 N. Caroline St.

23C. DATE SIGNED: Oct. 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried

24B. DATE: Oct. 4/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Fred W. Orzechowski

ADDRESS: 1930 Eastern Ave 1192

VS 150

G78555

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G78555

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SOPHIE NETZER
2. DATE OF DEATH: 9/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5136 Stafford Rd
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-21
D. STREET ADDRESS (If rural, give location): 5136 Stafford Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | March 18, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| domestic | | Germany | U.S.A. |

13. FATHER'S NAME: August Rust
14. MOTHER'S MAIDEN NAME: Johanne Fangmann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Henry Netzer ADDRESS: 5136 Stafford Rd.

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Cerebral Hemorrhage | 4 days |
| DUE TO | | |
| (B) | Hypertensive Cardio Vas ? | |
| DUE TO | Disease | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* ____, 19 46 *to* Sept 30, 19 49 *that I last saw the deceased alive on* Sept 30 19 49 *and that death occurred at* 5A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. P. Von Schwedler M.D. | 4818 Edmondson Ave | Sept 30 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Good Shepard | Rogers ave. Howard Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 - 1949 | Huntington Williams, M.D. | McNabb & Son | Catonsville |

VS 150

937

G78556 St Ashmore 3700 Johnson Blvd G78556

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Edward F. Lewis

2. DATE OF DEATH: Sept. 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1826 Linden Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1826 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | Mar. 19. 1869 | 80 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Analist, retired | Agriculture Dept of Va. | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 229-01-2430 | Miss Margaret Gore, 1826 Linden Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocarditis — Arteriosclerosis — DUE TO — 3 Weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility — DUE TO — 3 yrs.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* January, 19 49 *to* Sept 30, 19 49, *that I last saw the deceased alive on* Sept 30, 19 49, *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Harry Ashmore, M. D. | 4 W Mt Vernon Pl | 10/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10/1/49 | Oakwood | Richmond, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 1 - 1949 | Huntington Williams, MD | William Cook, Inc., 1217 St. Paul St. |

VS 150

937

G78557

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78557

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY A. ZILONKA
2. DATE OF DEATH: 9/28/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3032 STRICKLAND ST
c. Length of stay in Baltimore: 65 YRS (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-06
D. STREET ADDRESS (If rural, give location): 3032 STRICKLAND ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | White | Widow | 6/16/1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | GERMANY | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ANTON LORENZ | ANNA - |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | NONE | EARL J. ZILONKA | 3032 Strickland St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Arteriosclerotic Myocarditis | 1 yr. |
| DUE TO (B) | Generalized Arteriosclerosis | ? |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 19 49 *to* Sept. 28, 1949, *that I last saw the deceased alive on* Sept. 28, 1949, *and that death occurred at* 8:40 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas B. Schreiber M. D. | 54 S. Fulton Ave. | 9-29-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 - 1949 | Huntington Williams, M.D. | Roll G Bm. Walton | Orrett Stricker Pk |

VS 150

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G78558

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17° Registered No. G78558

1. NAME OF DECEASED (Type or Print): Edith E. Stevens

2. DATE OF DEATH: Sept. 29th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3016 E. Monument St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 7-11
D. STREET ADDRESS (If rural, give location): 3016 E. Monument Street

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | March 29th 1886 | 63 | 6 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Calvert County | |

13. FATHER'S NAME: Winfield Robinson

14. MOTHER'S MAIDEN NAME: Annie Grierson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Orville Stevens - 3016 E. Monument St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Carcinoma Breast (L.) | May 5-48 |
| DUE TO | Mediastinal Metastases | |
| (B) | | |
| DUE TO | Myocardial Insufficiency | |
| (C) | Edema & Gen. Anasarca | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July-1-48 | Radical Mastectomy (Carcinoma) | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May-5- 1948 *to* Sept 29- 1949 *that I last saw the deceased alive on* Sept 29, 1949 *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. G. Geyer M.D., M. D. | 156 N. Milton Ave. | Sept 30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 10-3-49 | Parkwood Cemetery | Taylor Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 1 - 1949 | Huntington Williams, M.D. | Frederick D. Mitchell Inc. 3016 E. Monument St |

VS 150

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G78559

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G78559

1. NAME OF DECEASED (Type or Print): MR. FREDERICK EARL DERBY
2. DATE OF DEATH: 30 SEPT 49
3. PLACE OF DEATH: a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEM. HOSPITAL
c. Length of stay in Baltimore: UNK. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: MARYLAND; B. COUNTY: BALTIMORE; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 11-03; D. STREET ADDRESS (If rural, give location): CONGRESS HOTEL
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: 25 AUGUST 1875
9. AGE (In years last birthday): 74 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNK.
10B. KIND OF BUSINESS OR INDUSTRY: UNK.
11. BIRTHPLACE (State or foreign country): CONNECTICUT (Meridan)
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Albert Osborne Derby
14. MOTHER'S MAIDEN NAME: Anna Gertrude Burgess
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
16. SOCIAL SECURITY NO
17. INFORMANT: AUSTIN C. DERBY; ADDRESS: 806 RUDGLEIGH ROAD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia — DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Nephrosclerosis — DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cirrhosis of liver, Arteriosclerotic Heart disease

INTERVAL BETWEEN ONSET AND DEATH: 1½ MONTHS

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 AUGUST, 1949, *to* 30 SEPT, 1949, *that I last saw the deceased alive on* 30 SEPT, 1949, *and that death occurred at* 4:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alvin Bouglass M. D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 9-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 10/2/49
24C. NAME OF CEMETERY OR CREMATORY: Poughkeepsie Rural Cem.
24D. LOCATION (City, town, or county) (State): Poughkeepsie, N. Y.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

Correct age is especially important. Physicians - please write plainly.

124 B

G78560

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78560

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BESSIE HELEN WISNER

2. DATE OF DEATH 9-30-49

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hosp. for the Women of Maryland

3c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10
D. STREET ADDRESS (If rural, give location) 909 Woodbourne ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Nov. 15, 1878 | 70 | 10 / 15 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| no | no | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Charles L. Burkhart

14. MOTHER'S MAIDEN NAME: Henrietta Davis

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mr. J. Grason Wisner | 909 Woodbourne Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) adenocarcinoma of kidney

DUE TO

(B) multiple bone metastases

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1-17, 1949 *to* 9-30, 1949 *that I last saw the deceased alive on* 9-30, 1949, *and that death occurred at* 4:07 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. P. Benson, Jr. M.D. | Women's Hosp. | 9-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

52a

G78561
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 928561

1. NAME OF DECEASED (Type or Print) Ida Brafman,

2. DATE OF DEATH Sept. 29th/1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Marlboro Aprt.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-01
D. STREET ADDRESS (If rural, give location) Marlboro Apts.

c. Length of stay in Baltimore life (Yrs. Mos. Days)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year Months, Days | If under 24 hours Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | March 4th. 1870. | 79 | 6 25 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | none | Balto. Md. | |

13. FATHER'S NAME Samuel Brafman

14. MOTHER'S MAIDEN NAME Babet Brafman.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | I.H. Orth, | N.Y. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Thrombosis | 1 day |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arterio-sclerosis - hypertension | 5 yrs |
| | DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from years of life 1870, to Sept 29, 1949, that I last saw the deceased alive on Sept 27, 1949 and that death occurred at 6:25 m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J Frederick Lantz M. D. | Temple Garden Aprt. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Oct. 2nd, 1949. | Oheb Shalom | Balto. Md. |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 - 1949 | Huntington Williams, M.D. | Wm Goodman's Son | 1902 Eutaw Pl. |

VS 150

94a

131991

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78562

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Oree Rollerson

2. DATE OF DEATH: 9- 29- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 7 Years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3033 Southland Ave. Z 25

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | S | Sept. 12 1913 | 36 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | S.C. | |

13. FATHER'S NAME: Melvin

14. MOTHER'S MAIDEN NAME: Lucille McDonald

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Records Balto. City Hospital | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Arterioler Nephrosclerosis

DUE TO

(C) Malignant Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10- 21- 48 Prev. Admission | Hypertension | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9- 19- , 1949, *to* 9- 29- , 19 49 *that I last saw the deceased alive on* 9- 29- , 19 49 *and that death occurred at* 7.05 Am. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. S. Logan M. D. | B.C.H. 4940 Eastern Ave. | 9- 30- 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Oct 1. 49 | Sumter | South Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 - 1949 | Huntington Williams, M.D. | Isaiah L Brown - Son | 108 W Montgomery St |

VS 150

131a

G78563 G78563

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 174

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edythe Etchison

2. DATE OF DEATH 10-1-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home Hospital
c. Length of stay in Baltimore 2 Yrs. 1/2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Frederick Carroll County
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt. Airy
D STREET ADDRESS (If rural, give location) Park Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | married | 1/21/88 | 61 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Maryland | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Tregoning | Clora Kidd |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Hospital Records |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH 2½ yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1947 | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7-3-49, 19__, *to* 10-1-49, 19__, *that I last saw the deceased alive on* 10-1-49, 19__, *and that death occurred at* 6:45 a.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Mitchener Jr M. D. | Church Home Hospital | 10-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-3-1949 | Pine Grove | Mt. Airy. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 - 1949 | Huntington Williams, M.D. | C. M. Waltz | Winfield, Md. |

VS 150

48 R

Correct age is especially important. Explanatory [illegible]

G78564 ✓ G78564

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Flossie Williams

2. DATE OF DEATH: 9-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 11-04
D. STREET ADDRESS (If rural, give location): 1317 Madison Ave. (Nightengale Home)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | ? | 40? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | N.C. | |

13. FATHER'S NAME: Willie Williams (D)

14. MOTHER'S MAIDEN NAME: Ida Diggs

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Possible Miliary Tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Undiagnosed Disease | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-15-49 | Node Biopsy | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-8- , 19 49 , *to* 9-24 , 19 49 *that I last saw the deceased alive on* 9-24 , 1949 , *and that death occurred at* 11:00 P. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Cozen M. D. | 4940 EASTERN AVENUE | 9-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 3-49 | Mt Calvery Cem. | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Bway |

VS 150

13 B

078565

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 078565

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MILTON HOMER PROBST

2. DATE OF DEATH: September 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 1738 Langley Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Widowed | Apr. 19- 1883 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hazelton .. Penna
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob Probst
14. MOTHER'S MAIDEN NAME: Hannah Faust
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Aubrey Oswald - ADDRESS: 1738 Langley

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Sept. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Bur.
24B. DATE: Oct 3-1949
24C. NAME OF CEMETERY OR CREMATORY: Mountain View
24D. LOCATION (City, town, or county) (State): Hazelton .. Penna

DATE RECEIVED BY LOCAL REGISTRAR: OCT 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John G. Connelly
ADDRESS: 918 Eastern Ave

94a

VS 151

678:66

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 678:66

1. NAME OF DECEASED (Type or Print): ARTHUR J. Eckels

2. DATE OF DEATH: 28 Sept. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-07
D. STREET ADDRESS (If rural, give location): 2637 Auguith Ste

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital (DOA)

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 3-14-1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Sun Paper
11. BIRTHPLACE (State or foreign country): Balto., Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Eckels
14. MOTHER'S MAIDEN NAME: Eliz. Benner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Florence Eckels ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 28 Sept. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 3-1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John B. Connelly
ADDRESS: 498 Eastern Ave Balto 24, Md

VS 151

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78567 ✓ 3567

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

18 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Hattie V. Foust

2. DATE OF DEATH SEP 29 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-06

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2419 Maryland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1-11-07 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Pa. | |

13. FATHER'S NAME Edward Gladfelter

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 219-22-8401 | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (a) Cancer of Kidney Chypernephroma? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (b) with Metastasis to lungs, liver and spine | (6 mos?) |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | DUE TO (c) Paraplegia, due to cord compression | 5 days |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/29/49 | Metastatic Carcinoma to Spine | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-28- 1949 *to* 9-29 1949, *that I last saw the deceased alive on* 9-29- 1949 *and that death occurred at* 6 00 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE OF M.D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maurice L. Brown | JOHNS HOPKINS HOSPITAL | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 10-3-1949 | Harmans Mem | York Co. Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 2 - 1949 | Huntington Williams, M.D. | John C. Wilt Inc. | 2435 E. Oliver St |

VS 150

52a

G78568 G78568

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAE TAULTON

2. DATE OF DEATH: Oct. 1

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

C. Length of stay in Baltimore: 30 years

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 2-02
D. STREET ADDRESS (If rural, give location): 1840 GOUGH ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | Feb. 5, 1905 | 44 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE W. NOCE

14. MOTHER'S MAIDEN NAME: R

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. HARLEN TAULTON ADDRESS: (Same)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

(B) Subarachnoid Hemorrhage

DUE TO

(C) Uremia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Heart Failure

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/30 10 PM, 1949 to 10/1 5:30 AM, 1949, *that I last saw the deceased alive on* 9/30, 1949, *and that death occurred at* 5:25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert E. Enders M. D.

23B. ADDRESS: Church Home Hosp.

23C. DATE SIGNED: 10/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Oct. 4 1949

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: Park Heights

24D. LOCATION (City, town, or county) (State): Brunswick Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: C. A. Sites Bro ADDRESS: Brunswick Md

VS 150

131a

G78569

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51 Registered No. G78569

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA YOUNGBAUER
2. DATE OF DEATH: SEPT. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5305 PLAINFIELD AVE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 21 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-01
D. STREET ADDRESS (If rural, give location): 5305 PLAINFIELD AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | MAY 4, 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WORK | AT HOME | GERMANY | U.S.A. |

13. FATHER'S NAME: FRANZ DICK
14. MOTHER'S MAIDEN NAME: UNKNOWN

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | ALOYSIUS YOUNGBAUER | 5305 PLAINFIELD AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Liver | 4 Months |
| DUE TO (B) | Adeno Carcinoma of head of Pancreas | 9 Months |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Jan 24/49 | Carcinoma Head of Pancreas | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Jan 23 1949, to Sept 28, 1949 that I last saw the deceased alive on Sept 28 1949, and that death occurred at 9.55 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William K. Draught M.D. | 10 E. Biddle St. | 9/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-3-49 | HOLY REDEEMER CEM | 4430 BELAIR RD. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 2 - 1949 | Hunterton Williams M.D. | Charles S. Zeiler | 901 S. Conkling St |

VS 150

469

G78570 BALTIMORE CITY HEALTH DEPARTMENT G78570

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 4

1. NAME OF DECEASED (Type or Print): Jacob R. Legum
2. DATE OF DEATH: Oct. 1 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3100 N. Hilton St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 33 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3100 Hilton St 15-38

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 25. 1880 | 68 | 10 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Auto Dealer | Auto Dealer | Lithaunia | U.S. |

13. FATHER'S NAME: Abaham Legum
14. MOTHER'S MAIDEN NAME: Anna Balser

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 212-16-8904 | Brother Harry | 3106 N. Hilton St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Aug. 11 1949

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 11, 1949 *to* Oct 1, 1949, *that I last saw the deceased alive on* Oct 1 1949, *and that death occurred at* 6:10 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel R. Legum M. D. | 126 E. North Ave | 10/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 2, 1949 | Windsor Mill Road Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Oct 2 1949 | Thomas Worthington for Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

94a

G78571 ✓ G78571

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4 no. 1 Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT SOCOLOFF
2. DATE OF DEATH: 10-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2115 Callow Ave
C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-02
D. STREET ADDRESS (If rural, give location): 2115 Callow Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: —1876
9. AGE (In years last birthday): 73 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookseller
10B. KIND OF BUSINESS OR INDUSTRY: rag
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Sonia Socoloff ADDRESS: 2115 Callow

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) General arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept-18-1949 *to* Oct-2-1949 *that I last saw the deceased alive on* Oct-1-1949 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Herman Seidel M. D.
23B. ADDRESS: 2404 Eutaw Pl
23C. DATE SIGNED: 10/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-2-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rhaedale
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: Oct 3 1949
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR: Jack Levin Inc. ADDRESS: 2400 E. Eutaw Pl.

94a

Correct age is especially important. Physicians, please write plainly.

VS 150

G78572

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 17 Registered No. G78572

1. NAME OF DECEASED (Type or Print): SARAH CATHERINE GREENBERG
2. DATE OF DEATH: 10-1-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOCTOR'S HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 15-11
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3612 Sequoia Avenue
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1899
9. AGE (In years last birthday): 49 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Tobah
14. MOTHER'S MAIDEN NAME: Pauline Myerson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Samuel Greenberg ADDRESS: 3612 Sequoia Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast (metastatic)
DUE TO
(B) Carcinoma of breast (metastatic)
DUE TO
(C) Carcinoma of breast (metastatic)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/3/49, 19__, *to* 10/1, 1949 *that I last saw the deceased alive on* 10/1, 1949, *and that death occurred at* 1:55 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Greenberg M. D.
23B. ADDRESS: 2320 N Charles
23C. DATE SIGNED: 10/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-2-49
24C. NAME OF CEMETERY OR CREMATORY: WASHINGTON BLVD
24D. LOCATION (City, town, or county) (State): BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR: OCT 2 1949
REGISTRAR'S SIGNATURE: Hunterstown Nitterauer, M.D.
25. FUNERAL DIRECTOR: JACK LEWIS INC. ADDRESS: 2100 EUTAW PL

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G78573

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 G78573 23

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA BAUM

2. DATE OF DEATH: 10-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3337 Dolfield ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3337 DOLFIELD AVE

c. Length of stay in Baltimore: 37 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15-11
D STREET ADDRESS (If rural, give location): 3337 DOLFIELD AVE

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MORRIS
14. MOTHER'S MAIDEN NAME: TOBY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: LOUIS BAUM - 3337 DOLFIELD AVE ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10½ hours

DUE TO

(B) arteriosclerotic Hypertension — 20 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1944, to Oct 1, 1949, that I last saw the deceased alive on Oct 1, 1949, and that death occurred at 4:30 A m., from the causes and on the date stated above.

23A. SIGNATURE: William J. Sullivan M. D.
23B. ADDRESS: 2911 Harrison Blvd
23C. DATE SIGNED: Oct 1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-2-49
24C. NAME OF CEMETERY OR CREMATORY: ROSEDALE
24D. LOCATION (City, town, or county) (State): BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: JACK LEWIS INC. ADDRESS: 2100 EUTAW PL.

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078574

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 43 078574

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Burns

2. DATE OF DEATH: 10/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 616 W. 40th St. & E. University Pkwy

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 616 W. 40th St. & E. University Pkwy

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | Dec 16/1875 | 73-72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto Md | |

13. FATHER'S NAME: James J Gallagher

14. MOTHER'S MAIDEN NAME: Mary Stevens

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | John H Burns | 616 W 40th St |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18 | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) H. A. C. V Disease | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| C. L. Jakowski M.D. | | 10/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 4/1949 | New Cathedral | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 2 1949 | Thomas Stockton Williams, M.D. | Harry A Kramer | 4204 Ferdinand Ave |

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

47° 1 G78545

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Nunner

2. DATE OF DEATH: 9/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: life. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 1700 E. 30th St., Balto.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married. | Nov. 30 1882 | 66 | 9 | 29 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | unknown | Baltimore, Md. | U. S. A. |

13. FATHER'S NAME: William Nunner

14. MOTHER'S MAIDEN NAME: Margaret Mertens

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.: 217-07-5932

17. INFORMANT: Mrs. Maria T. Nunner — ADDRESS: 1700 E. 30th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Myocardial Infarction | 10 days |
| DUE TO (B) | Coronary Thrombosis | 10 days |
| DUE TO (C) | Generalized arteriosclerosis | unknown |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| none | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 5 pm 9/29/49 9:10 pm |

22. *I hereby certify that I attended the deceased from* 9/29/49 *to* 9/29/49 *that I last saw the deceased alive on* 9/29/49 *and that death occurred at* 9:10 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas B Turner M. D. | Mercy Hospital | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Holy Redeemer | Belair Road |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 2 - 1949

REGISTRAR'S SIGNATURE: Remington Hilleary M.D.

25. FUNERAL DIRECTOR: Lindsey Sons — ADDRESS: Lindsey

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): James Madigan

2. DATE OF DEATH: 9/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital

c. Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Intramural
D. STREET ADDRESS (If rural, give location): Frederick Rd & Paradise Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9-8-1872
9. AGE (In years last birthday): 77 — If under 1 Year: Months —, Days —; If under 24 Hours: Hours —, Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Keeper
10B. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Madigan
14. MOTHER'S MAIDEN NAME: Mary Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mary A. Lang ADDRESS: Frd Rd & Paradise Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage, left | 4 days |
| DUE TO (B) | Arteriosclerotic Hypertensive CVD | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/20 1949 to 9/29, 1949, that I last saw the deceased alive on 9/29, 1949, and that death occurred at 10:05 P.m., from the causes and on the date stated above.

23A. SIGNATURE: Herbert J. Kerikas M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 9/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 3 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 2 - 1949
REGISTRAR'S SIGNATURE: Penrington for Williams, M.D.
25. FUNERAL DIRECTOR: J. F. Wheeler & Son ADDRESS: 1300 Eastern Ave

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

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BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Nellie Williams

2. DATE OF DEATH: Oct. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: 0 Yrs. Mo. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bylesville
D. STREET ADDRESS (If rural, give location)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 11, 1869
9. AGE (In years last birthday): 80
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Williams
14. MOTHER'S MAIDEN NAME: Mary Parry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of left pelvis and inguinal region, type undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 24, 1949, *to* Oct 2, 1949, *that I last saw the deceased alive on* Oct 2, 1949, *and that death occurred at* 1245 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Francis C Wilson M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: Oct 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 4 1949
24C. NAME OF CEMETERY OR CREMATORY: Glatzville
24D. LOCATION (City, town, or county) (State): York Co. Pa.

DATE RECEIVED BY LOCAL REGISTRAR: 10-2-49
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Hubert P. Harbeina
ADDRESS: Delta, Pa.

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G78578 BALTIMORE CITY HEALTH DEPARTMENT G78578

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Annie M. Wittig
2. DATE OF DEATH: Sept. 30, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 3520 N. Hilton Rd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shriners Nursing Home
C. Length of stay in Baltimore: 69 years (Yrs. / Mos. / Days)
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4726 Park Heights Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Aug 12 1871 | 78 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Howard Co, Md | U.S.A. |

13. FATHER'S NAME: John F. Espey
14. MOTHER'S MAIDEN NAME: Elizabeth Espey.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mr John L. Wittig Jr | 4726 Park Heights Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Diabetes Mellitus — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 31 *to* Sept 30th, 19 49, *that I last saw the deceased alive on* Sept 29, 19 49, *and that death occurred at* 10:15 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel A Cudas M. D. | 5611 Pimlico Rd | Oct 2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Loudon Park | Balto, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-2-49 | Huntington Williams, MD | Sterling Byers | 5005 Pk Hgts Ave |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

G78579 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josias Price

2. DATE OF DEATH: Oct. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400 N. Lefingtion St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aged Women's and Aged Men's Homes

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 19-02
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | May 13 1860 | 89 | 4 / 19 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Dr. James H. Price

14. MOTHER'S MAIDEN NAME: Mary Groome Ringgold

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: No

17. INFORMANT 2nd Read Cousin ADDRESS: 1400 N. Lefingtion Street.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Arteriosclerosis, Hypertension

DUE TO Acute Cerebro-vascular disease

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June, 1949 *to* October 2, 1949 *that I last saw the deceased alive on* October 2 1949 *and that death occurred at* 10:00 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Neal and Edward Day M. D. | 4-E-33rd St - Balto 18 | Oct 2, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | OCT. 4, 1949 | St Paul Cem. | Kent Co. MARYLAND |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | J. Willis Wells | CHESTERTOWN MARYLAND |

VS 150

83a

G78580

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

191 Registered No. G78580

BIRTH NO.

1. NAME OF DECEASED (Type or Print): J. Elmer Esbenshade

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2907 W. North Ave.,
C. Length of stay in Baltimore: 3-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-16
D. STREET ADDRESS (If rural, give location): 2907 W. North Ave.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Feb. 28, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Farmer | | Pa. | |

13. FATHER'S NAME: J. Elmer Esbenshade

14. MOTHER'S MAIDEN NAME: Elizabeth Hartmann

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | none | Mrs. John Donahue | 2907 W. North Ave., |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Liver & Ear — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO Secondary Anemia — 6 mo
(B) Cardiac Asthenia — 2 hrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1949, *to* Oct 1, 1949, *that I last saw the deceased alive on* Oct 1, 1949, *and that death occurred at* 7.30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. Elv Kam | 1212 St Paul St | Oct 2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/49 | Faggs Manor | Cochranville, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Huntington Williams, M.D. | G. Howard Strong | 3207 W. North Ave., |

VS. 150

53

CERTIFICATE CORRECTED 10/4/49 ✓ E 890.0 G78581

G78581

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. N-9680

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) Franklin M Brown | 2. DATE OF DEATH Oct. 1, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland Balto | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-01 |
| c. Length of stay in Baltimore Balto (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location) Pelham ave 2853 Pelham ave. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH (Month) (Day) (Year) | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | NOVEMBER 27, 1883 Nov 27 1878-70 | 65 | | |

| | |
|---|---|
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman Chauffer | 10B. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country) Balto | 12. CITIZEN OF WHAT COUNTRY? U.S.A |
| 13. FATHER'S NAME Charles J Brown | 14. MOTHER'S MAIDEN NAME Not Known |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
| 17. INFORMANT Mrs Chas Brown, 2853 Pelham Ave | ADDRESS |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon Monoxide Poisoning

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Pelham ave 2853 Pelham ave. |
|---|---|---|
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 1, 1949 1:3[illegible] Am. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? one burner on but unlit (gas stove) |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Oct. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 4-49 | New Cath Cem | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Huntington Williams, M.D. | Jos J Iten & Son | 3001 Kentucky ave |

VS 151

178a

G78582 JL - 132170

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 1 Registered No. G78582

1. NAME OF DECEASED (Type or Print): John Miles

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 12 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1032 Wilbert Ct.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Sep. | Feb. 1, 1915 | 34 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Steve Miles

14. MOTHER'S MAIDEN NAME: Maggie Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT ADDRESS: B. C. H. Records, 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Lower Nephron Nephrosis | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 27, 1949, *to* Oct. 1, 1949 *that I last saw the deceased alive on* Oct. 1, 1949 *and that death occurred at* 1.40 pm *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.

23B. ADDRESS: 4940 Eastern Ave.

23C. DATE SIGNED: Oct. 1, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/5/49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State): Chester, S. C.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Adolphus Halstead

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1212

G78583

M M. 131173

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78583

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary, Hepding.

2. DATE OF DEATH: Sept. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2819 Hampden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | March 16,1877 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Patrick Scanalon
14. MOTHER'S MAIDEN NAME: Catherine Craig.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: B.C.H. Records 4940 Eastern Ave. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia-Pyelonephrosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-vascular Disease with Coronary Insufficiency Diabetes Mellitus—Severe

DUE TO

(C) CERTIFICATION APPROVED BY For Dr. William Helfrich per RS Finken M.D.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture Right Hip

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 8-29-49 | Fracture right femoral neck. | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | 2819 Hampden Ave. 12/7 |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Aug. 9, 1949 ? m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Was hanging up clothes, slipped and fell to ground |

22. *I hereby certify that I attended the deceased from* 8-19- , 19 49 *to* 9-30- , 19 49, *that I last saw the deceased alive on* 9-30-49 , *and that death occurred at* 1.10p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rogers M. D. | 4940 Eastern Ave | 10-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 3/49 | New Cathedral | Frederick Rd Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3- 1949

REGISTRAR'S SIGNATURE: Custer Williams, M.D.

25. FUNERAL DIRECTOR: Custer E. Donovan ADDRESS: 3818 Roland Ave

VS 150

TO BE APPROVED BY MEDICAL EXAMINER

186a

G78584 Ruth E. Easton 2916 Huntingdon Ave

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78584

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RUTH E. EASTON

2. DATE OF DEATH: Oct 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2916 Huntingdon Ave

c. Length of stay in Baltimore: Yrs. 1yr Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2916 Huntingdon Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Married | Aug 24 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Maryland | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jesse McCandless | Sophia Pierce |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS | |
|---|---|---|---|
| | | Jay H. Easton | 2916 Huntingdon Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Glomerular Nephritis Hepatic Cirrhosis with Ascites | 9 mos. |
| DUE TO (B) | Diabetes Mellitus with Gangrene left leg due to arteriosclerosis | 2 wks. |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* Oct. 1, 1949, *that I last saw the deceased alive on* Sept. 30, 1949, *and that death occurred at* 10:10 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M. D. | 501 Sheridan Ave | 30 Oct. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 4/49 | Woodlawn | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS | |
|---|---|---|---|
| OCT 3 - 1949 | Interim for Williams, M.D. | Euston E. Donovan | 3518 Poland Ave. |

VS 150

61

G78585

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78585

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martha K.Pearson

2. DATE OF DEATH: Oct.1,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2101 Cold Spring Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elkins Nursing Home

C. Length of stay in Baltimore: Yrs. 50 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
2101 Cold Spring Lane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md. 27-15
d. STREET ADDRESS (If rural, give location): 2101 Cold Spring Lane

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov.25,1886
9. AGE (In years last birthday): 85
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John S.Fearson
14. MOTHER'S MAIDEN NAME: Martha K.Cartwright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) --
(If yes, give war or dates of service) --
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs.Bertha L.Browne
ADDRESS: 2235 Lake Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) GENERALIZED ARTERIO-SCLEROSIS.
DUE TO
(B) WITH. CHRONIC MYOCARDITIS. 15 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 15, 1946, *to* Oct. 1, 1949, *that I last saw the deceased alive on* Sept 30, 1949, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Norman R. Kleiman M. D.
23B. ADDRESS: 3803 Edmondson Ave
23C. DATE SIGNED: 10-2-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct.3,1949
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem.Park
24D. LOCATION (City, town, or county) (State): Balto. Md. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Philip Herwig Son
ADDRESS: 2021 Orleans St.

VS 150

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G78586

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78586

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Nemec

2. DATE OF DEATH: Sept 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 404 N. Robinson

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 55 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-01
D. STREET ADDRESS (If rural, give location): 404 N. Robinson

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Dec 4, 1880 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer

10B. KIND OF BUSINESS OR INDUSTRY: Grocery Owner

11. BIRTHPLACE (State or foreign country): Czechoslovakia

12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: Frank Nemec

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Edward Nemec ADDRESS: 404 N. Robinson

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

(B) Generalized Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/47, 19__, *to* 9/30, 1949, *that I last saw the deceased alive on* 9/30, 1949, *and that death occurred at* 1:10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry J. Houska M. D.

23B. ADDRESS: 333 S. East Ave.

23C. DATE SIGNED: 9/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct 3/49

24C. NAME OF CEMETERY OR CREMATORY: Oak Hill

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Frank Brachlson ADDRESS

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carl H. Keller

2. DATE OF DEATH: 9-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-20
D. STREET ADDRESS (If rural, give location): 2900 Strathmore Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 5, 1908
9. AGE (In years last birthday): 40 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lee/ Room Clerk
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian Keller
14. MOTHER'S MAIDEN NAME: Caroline Mauers (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bilateral Pulmonary Tuberculosis Far Advanced — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Right Heart Failure
Diabetes- Severe
DUE TO Adrenal Tumor Masses, Bilateral
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 5-10-49
19B. MAJOR FINDINGS OF OPERATION: Phrenic Crush for pulmonary tuberculosis
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 2-22, 19 49, *to* 9-29, 19 49, *that I last saw the deceased alive on* 9-29, 19 49, *and that death occurred at* 3:45 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 9-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-3-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck. ADDRESS: 5305 Harford

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lena Hammonds — N-820.0 — 2. DATE OF DEATH: Oct. 1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Schriner Nursing Home
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-17
D. STREET ADDRESS (If rural, give location): 4922 Palmer Ave.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | May 7-1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Va. | |

13. FATHER'S NAME: John Padgett
14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. John Davis | 2226 E. Chase St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular renal disease — (Interval between onset and death) 6 mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Fracture left hip — 2 mo

CERTIFICATION APPROVED BY
R S Fraher M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident | nursing home | Shriner's Nursing Home, 3520 Hilton St. |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| August ?, 1949 ? m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Rolled out of bed on to floor 15/11 |

22. *I hereby certify that I attended the deceased from* June, 1941, *to* 10/1, 1949, *that I last saw the deceased alive on* 10/1, 1949 *and that death occurred at* 6.20 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Helen G. Mayennis M.D. | 1445 N. Gay St | 10/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 4-49 | Baltimore Mem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 1949 | Huntington Williams, M.D. | John A. Waller | 2334 Jefferson St. |

VS 150

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G78589

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 1

G78589 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY THOMAS

2. DATE OF DEATH Sept. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1330 Myrtle St.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-03
D. STREET ADDRESS (If rural, give location) 1330 Myrtle Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widow | Dec. 16, 1868 | 80 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Benjamin Wallace
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-20-49, 19 49 *to* 9-29-49, 19 49, *that I last saw the deceased alive on* 9-29, 19 49 *and that death occurred at* 8:20 A. M. *from the causes and on the date stated above.*

23A. SIGNATURE Charles F. Weidler M. D.
23B. ADDRESS 22 E. Franklin
23C. DATE SIGNED 9-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-3-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Frances A. Hemsley W. Biddle
ADDRESS 548

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BIRTH NO. B.C.R-23735

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78590

1. NAME OF DECEASED (Type or Print): CatherineBain

2. DATE OF DEATH: 10-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 26-36
D. STREET ADDRESS (If rural, give location): 1421 Stromyer Way (24)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Oct. 31, 1948 | | 11 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Bain
14. MOTHER'S MAIDEN NAME: Regina Weininger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Edema and Myocardial Failure
DUE TO
(B) Severe Malnutrition and Scurvey
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30, 19 49 *to* 10-1, 19 49 *that I last saw the deceased alive on* 10-1, 19 49, *and that death occurred at* 3:55 A., *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/3/49
24C. NAME OF CEMETERY OR CREMATORY: Woodland Mem Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGIS: OCT 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. McCorkle
ADDRESS: 1819 E. Fort Ave

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TO BE APPROVED BY MEDICAL EXAMINER.

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G78591

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78591

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie M. Klein

2. DATE OF DEATH: Oct 1-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1302 Pentwood Rd

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1302 Pentwood Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | widowed | Jan 28 1876 | 73 | 8 | 3 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Theodore Billings
14. MOTHER'S MAIDEN NAME: Elizabeth M. Barnes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Blythe Klein 5761 Edgewood Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 2 1949 *to* Oct. 1, 1949, *that I last saw the deceased alive on* Oct 1, 1949 *and that death occurred at* 8:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Laurel B. Mc M.D.
23B. ADDRESS: 1331 S Monastery
23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 4-1949
24C. NAME OF CEMETERY OR CREMATORY: Woodland Park Cem.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Joseph Grace & Son 2012 Eutaw Pl.

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G78592 ✓ 334 G78592

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): TRESIA C. GLANZER

2. DATE OF DEATH: Sept. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3010 Baker St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3010 Baker St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widow | Sept. 14, 1870 | 79 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Westmorland Co., Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Peter Salzig | Barbara Mayer |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Helen K. Gaigley | 3010 Baker St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral apoplexy | One day |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arterio-Sclerosis with Hypertension | ? |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 6, 1949, *to* Sept. 30, 1949, *that I last saw the deceased alive on* Sept. 29, 1949, *and that death occurred at* 6:05 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maurice E. Shamer M. D. | 3 Boone Court | 10-1-'49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Registrar for Baltimore, Md. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

83a

G78593 ✓ G78593

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY ALICE LOUGHLIN

2. DATE OF DEATH: 10/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 75 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 4003 Garrison Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | Feb. 5, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Baltimore Md. | U.S. |

13. FATHER'S NAME: William Morgan

14. MOTHER'S MAIDEN NAME: Alice A. ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | NO | no | Mr. Warren M. Benser | 3704 Belle Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) Arteriosclerotic CVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: DIABETES, Ruptured Gall Bladder

INTERVAL BETWEEN ONSET AND DEATH:

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/30, 19 49 *to* 10/1, 19 49 *that I last saw the deceased alive on* 10/1, 19 49 *and that death occurred at* 10 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Max J. Miller M.D. | Sinai Hospital | 10/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

61

G78594

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78594

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martyn K. Coster

2. DATE OF DEATH: Oct 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 13 years (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 501 Cedarcroft Rd. 27-48

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married. | Feb. 25, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Credit Manager, U. Steel | U.S. Steel | Pennsylvania | |

13. FATHER'S NAME: Robert John Coster

14. MOTHER'S MAIDEN NAME: Helena Marie Wardenburg

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | no | Mrs. Ann Edith Coster - 501 Cedarcroft Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Bladder. | 2 mo. |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Papillomata of Bladder | 5 years. |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pulmonary Edema | 36 hours. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Sept. 27, 1949 | Carcinoma of bladder. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 26, 1949, *to* Oct. 1, 1949 *that I last saw the deceased alive on* Oct. 1, 1949, *and that death occurred at* 8:05 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm M Kimball | Union Memorial Hospital Baltimore | 10/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10/4/49 | Homewood Cem. | Pittsburgh, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

5212

G78595

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

45.0

Registered No. G78595

1. NAME OF DECEASED (Type or Print) FANNIE EVANS ELY

2. DATE OF DEATH Oct, 2nd, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gardenville Convalescent Home

c. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Raspeburg, Md.
D. STREET ADDRESS (If rural, give location) 603 Elmwood Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widowed | Jan, 20th, 1871 | 78 | 8 | 12 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Levi French

14. MOTHER'S MAIDEN NAME Mary Capprise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Wilbur Davis ADDRESS 603 Elmwood Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Congestive heart failure | 6 mos. |
| DUE TO (B) | Arteriosclerosis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Senility | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | None | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 18 June 1949 *to* 20 Oct 1949 *that I last saw the deceased alive on* 23 Sept 1949 *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mary L. Robinson M. D. | 5402 Harford Rd | 30 Oct 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/5/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Tunstall for Williams, M.D. | Lassahn Funeral Home | 7401 Belair Rd. |

VS 150

93E

G78596

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78596

1. NAME OF DECEASED (Type or Print): IRA MELVIN SMITH

2. DATE OF DEATH: Sept 30, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 12-05
D STREET ADDRESS (If rural, give location): 1715 Guilford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | April 7th, 1872 | 77 | 5 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Blacksmith | Retired 3yrs Ellicott Mach. | Pa. | USA |

13. FATHER'S NAME: David R. Smith

14. MOTHER'S MAIDEN NAME: Roseanna McCauan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO: 215-10-9382-A

17. INFORMANT: Mrs. Ira M. Smith ADDRESS: 1715 Guilford Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Embolus | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Auricular Fibrillation Congestive Failure | |
| DUE TO | | |
| | (C) Arteriosclerotic Heart Disease | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Benign Prostatic Hypertrophy | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 10, 1949, *to* Sept 30, 1949, *that I last saw the deceased alive on* Sept 30, 19 49, *and that death occurred at* 4:05 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Leon E Kanel M. D. | Sinai Hospital | 9/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/4/49 | Fork Methodist | Fork, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3- 1949 | Huntington Williams, M.D. | Lassahn Funeral Home | 7401 Belair Rd. |

VS 150

93D

G78597 ✓ E972.0 G78597

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ernestine McNair — N-968
2. DATE OF DEATH: Sept. 30, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-12
D. STREET ADDRESS (If rural, give location): 1209 Nolan Ct. Ap't. 3A
5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 11-6-1921
9. AGE (In years last birthday): 27 — If Under 1 Year: Months / Days; If Under 1 Day: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ERNEST Malette
14. MOTHER'S MAIDEN NAME: Lillie Hopkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Samuel McNair — ADDRESS: 1209 Nolan Ct.

## MEDICAL CERTIFICATION

correct age is especially important. Physicians, please write the

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1209 Nolan Ct. Ap't. 3A
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 30, 1949 12:30 A m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY Ooccur? 1 burner on but unlit (gas stove)

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: W. J. McCafferty, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Sept. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-4-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Albion Cemetery
24D. LOCATION (City, town, or county) (State): Ba. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William J. Lackman Sons Inc.
ADDRESS: 916

163H

G78598

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78598

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary E. Johnson Waters

2. DATE OF DEATH Sept. 30 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 814 N. Gilmor

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-03
D. STREET ADDRESS (If rural, give location) 814 N. Gilmore St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | M | Feb 15 1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Isaac Johnson

14. MOTHER'S MAIDEN NAME Julia Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT John Waters ADDRESS 814 Gilmor St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 hour

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Malignant Hypertension

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 8, 1949 *to* Sept 30, 1949 *that I last saw the deceased alive on* Sept 29, 1949, *and that death occurred at* 5 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE J. W. Anderson M. D.

23B. ADDRESS 1612 Edmondson Ave

23C. DATE SIGNED 10-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) 24B. DATE Oct 3

24C. NAME OF CEMETERY OR CREMATORY Mt Auburn

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 3 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR A. Halstead ADDRESS 918 Lanvale Ave

VS 150

83a

G78599

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Ward no. 1

G78599

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MARY R. DAUGHTERY

2. DATE OF DEATH Oct. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2609 Gibbons Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-06
D. STREET ADDRESS (If rural, give location) 2609 Gibbons Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Feb. 12, 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W. Rodgers

14. MOTHER'S MAIDEN NAME Mary Jane Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO ——

17. INFORMANT ADDRESS Mrs. Edgar Harrod, Sr. 4325 Marble Hall Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1

DUE TO

(B) Hypertension Cor in Vas. Dis. — 10

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* ——, 19 20 *to* Oct 1, 19 49, *that I last saw the deceased alive on* Oct 1, 19 49 *and that death occurred at* 3A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ruth S. Hinzey | 2700 HARFORD Rd. | Oct 2 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 4, 1949 | Loudon Park National | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS: Ullrich Funeral Home 2008 Orleans St.

VS 150

937

G78600

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44

G78600 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHNSON, ALICE R.

2. DATE OF DEATH: 9/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT HOSP.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 158 Dolphin
B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. Md.
D. STREET ADDRESS (If rural, give location): 158 Dolphin 11-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | N | Married. | 10/14/02 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Hartsville S.C. | U.S.A. |

13. FATHER'S NAME: Charles Richardson

14. MOTHER'S MAIDEN NAME: Delphia Archer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Oscar Johnson | 158 Dolphin |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Failure

DUE TO

(B) Hypertension

DUE TO

(C) arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/8, 1949 *to* 9/28, 1949 *that I last saw the deceased alive on* 9/28, 1949, *and that death occurred at* 5:20 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. H. Johns III M. D. | Provident Hosp. | 9/28 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/1949 | W.M. Calvary Cem. | Cedar Hill Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 – 1949 | Huntington Williams M.D. | Wm. Kate R. Williams | W. Lafayette |

VS 150

97

G78601

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78601

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hester Ryan.

2. DATE OF DEATH: 9-30-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1105 Mc Kean Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1105 Mc Kean Ave. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-04
D. STREET ADDRESS (If rural, give location) 1105 Mc Kean Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | C | Single | April 25, 1890 | 59 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Howard County, Md | U.S.A. |

13. FATHER'S NAME: Thomas Ryan.

14. MOTHER'S MAIDEN NAME: Emily Boardley.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Clara Ryan. | 1105 Mc Kean Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal disease — INTERVAL BETWEEN ONSET AND DEATH: 9 1 2 m

DUE TO Complications Anasarca

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO —

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

—

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 15 19 49 *to* Sept 29, 19 49, *that I last saw the deceased alive on* Sept 29, 19 49, *and that death occurred at* 10:10 am *m, from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1413 Druid Hill Ave | Oct 3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/1949 | Western Star Cem | Catonsville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3- 1949 | Huntington Williams, M.D. | Mrs. Katie R. Williams | N. Lehmann St. |

VS 150

131a

Melton ✓

G78602

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

31 Registered No. G78602

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie Melton

2. DATE OF DEATH: Sept 29 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3228 Barclay St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore ____ Yrs. ____ Mos. ____ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
3228 Barclay St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 12-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | 1896 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Seamstress | Self | N C | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1949, *to* Sept 29, 1949 *that I last saw the deceased alive on* ____ 19__ *and that death occurred at* 10:30 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis A. Johnson M. D. | 2329 Fairfield Ave | Oct. 3 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 3-1949 | Mt Calvary Cemetery | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3- 1949 | Huntington Williams M.D. | Robert F. Williams | 1525 McElderry St |

VS 150

83a

G78603 B.C. 49-21332

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1949 Registered No. G78603

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | MICHAEL GERALD KELLIHER |
| 2. DATE OF DEATH | SEPT. 29, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | FRANKLIN SQUARE |
| c. Length of stay in Baltimore | 7 HOURS (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | BORN IN HOSPITAL |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | 11-04 |
| D. STREET ADDRESS (If rural, give location) | — |
| 5. SEX | BOY |
| 6. COLOR OR RACE | WHITE |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | INFANT |
| 8. DATE OF BIRTH | SEPT. 29, 1949 |
| 9. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hours: Hours / Min. | 0 / 0 / 7 / 0 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | INFANT |
| 10B. KIND OF BUSINESS OR INDUSTRY | — |
| 11. BIRTHPLACE (State or foreign country) | BALTIMORE, MD. |
| 12. CITIZEN OF WHAT COUNTRY? | U. S. |
| 13. FATHER'S NAME | THOMAS GERALD KELLIHER |
| 14. MOTHER'S MAIDEN NAME | LEONA ESTELLE TOWNSEND |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | NO — |
| 16. SOCIAL SECURITY NO. | — |
| 17. INFORMANT / ADDRESS | MOTHER / 1312 LINDEN AVE. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ATELECTASIS

DUE TO

(B) MATERNAL PYELITIS - WITH TOXIC COURSE CAUSING PREMATURE LABOR.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | |
|---|---|
| 19A. DATE OF OPERATION | — |
| 19B. MAJOR FINDINGS OF OPERATION | — |
| 20. AUTOPSY? | YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | — |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | — |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | — |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | — m. |
| 21E. INJURY OCCURRED | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ |
| 21F. HOW DID INJURY OCCUR? | — |

22. *I hereby certify that I attended the deceased from* Sept. 29, 1949, *to* Sept. 29, 1949, *that I last saw the deceased alive on* Sept. 29, 1949, *and that death occurred at* 3 ? *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| Benjamin Amsterdam M. D. | Franklin Square Hosp. | Sept. 30 '49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| BURIAL | 10/3/49 | CATHEDRAL | Baltimore | |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| OCT 3 - 1949 | for Nilliams, M.D. | M. Faber & Sons | 1827 W. North Ave. |

VS 150

159

G78604

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0 G78604 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Paul R. Dyer S. S.

2. DATE OF DEATH: 9/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: 2 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): St. Mary's Seminary - Roland Park

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 2/23/1894 | 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forest
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Leominster Mass
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Dyer (dec'd)
14. MOTHER'S MAIDEN NAME: Elizabeth Furey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Elizabeth Crowley ADDRESS: Massachusetts

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cirrhosis of the liver | 5 |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/27 19 49 *to* 9/30 19 49, *that I last saw the deceased alive on* 9/30 19 49 *and that death occurred at* 7:10 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Herbert R. Gordon M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 9/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. Meeks and Son
ADDRESS: 805 W. Calvert St.

124 R

G78605 15092 G78605

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. B.C. 49-15092 — Registered No. 490

1. NAME OF DECEASED (Type or Print): Reginald Butler
2. DATE OF DEATH: 10-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1315 Whetcroat St
C. Length of stay in Baltimore: 2 mos (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balt
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md
D. STREET ADDRESS (If rural, give location): 1315 Whetcroat 15-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year, last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | | July 23-49 | 2 mos | 2 | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant | | Balto | U.S.A. |

13. FATHER'S NAME: John Butler
14. MOTHER'S MAIDEN NAME: Ruth Hurley (B)

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Ruth Butler | 1315 Whetcroat St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-1, 19 49, *to* 10-2, 19 49, *that I last saw the deceased alive on* 10-2, 19 49, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ben R Butler M.D. | 1126 Druid Hill Ave | 10-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/49 | Mt Auburn | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3-1949 | Huntington Williams, M.D. | Geo. A. Kelson | 1303 Eutaw |

VS 150

108

G78606

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 G78606

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Ruth H. Engleman

2. DATE OF DEATH 10-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 20-07

c. Length of stay in Baltimore Yrs. Life Mos. Days

D. STREET ADDRESS (If rural, give location) 506 Lyndhurst St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | Sept. 27, 1895 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady

10B. KIND OF BUSINESS OR INDUSTRY Stewart & Co.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm. Bernard Motshman

14. MOTHER'S MAIDEN NAME Catherine -------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 219-10-0026

17. INFORMANT (husband) ADDRESS Charles G. Engleman, 506 Lyndhurst St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pancreatitis?

DUE TO

(B) Acute Myocardial Infarction?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30, 1949, *to* 10-1, 1949, *that I last saw the deceased alive on* 10-1, 1949, *and that death occurred at* 8 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE R. G. Engleman Jr. M. D.

23B. ADDRESS Univ. Hosp

23C. DATE SIGNED 10-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 4/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore National

24D. LOCATION (City, town, or county) (State) 5501 Frederick Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 3- 1949

REGISTRAR'S SIGNATURE Carrington Williams, M.D.

25. FUNERAL DIRECTOR Harry A. Wirtz

ADDRESS 4101 Edmondson Ave.

VS 150

94a

G78607 BALTIMORE CITY HEALTH DEPARTMENT G78607

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mother M. Barbara Finn, O. S. F.

2. DATE OF DEATH: October 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3725 Ellerslie Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St, Elizabeth's Home 3725 Ellerslie Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 9-01

c. Length of stay in Baltimore: About 18 years (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 3725 Ellerdie Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W. | | May 28, 1861 | 88 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teaching

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Finn

14. MOTHER'S MAIDEN NAME: Ann Finn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mother M. Regina ADDRESS: 3725 Ellerslie Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1946 *to* Oct., 1949 *that I last saw the deceased alive on* 29 Sept., 1949 *and that death occurred at* 2 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. H. Kammer Jr. M. D. | 23B. ADDRESS: 501 Sheridan Ave | 23C. DATE SIGNED: 2 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: 10-3-49 | 24C. NAME OF CEMETERY OR CREMATORY: St. Elizabeths Home | 24D. LOCATION (City, town, or county) (State): Balto. MD.

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE: Tuntington Williams, M.D | 25. FUNERAL DIRECTOR: H. W. Jenkins & Sons Co. | ADDRESS: York Rd. 4905

VS 150

937

BIRTH NO. G78608

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78608

1. NAME OF DECEASED (Type or Print): James Dickerson

2. DATE OF DEATH: Oct. 2, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1127 Shields Place

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02

c. Length of stay in Baltimore: 75 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1127 Shields Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | C. | WIDOWER | July 4 1859 | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| WAITER | Private | Calvert Co. Md | U.S.A. |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Senility

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug 10, 19 49 *to* Oct 1, 19 49 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| N. Atwell Jones, M. D. | 3-3-4 Dolphin St | 10-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 5/49 | New Cathedral | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry H. Jenkins Sons — ADDRESS: 4905 York Rd

VS 150

937

G78609

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. G78609

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alexander Bowen

2. DATE OF DEATH Oct. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident

c. Length of stay in Baltimore 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02
D. STREET ADDRESS (If rural, give location) 1721 McCulloh St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Colored | Divorced | Dec. 4, 1883 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME George T. Bowen
14. MOTHER'S MAIDEN NAME Martha A. Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Edna B. Newton ADDRESS 338 Robert St.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18.

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: Undet.

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Essential hypertension — Undet

(C) Hypertension C.V.D — Undet

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mild congestive failure

19A. DATE OF OPERATION none
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/1/41, 19__, to 10/2/49, 19__, *that I last saw the deceased alive on* 10/2, 1949, *and that death occurred at* 6:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Francis D. Leeper M. D.
23B. ADDRESS Provident Hospital
23C. DATE SIGNED 10/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 5 1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 3 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Holland Funeral Home ADDRESS 1631 (931) Druid Hill Ave.

VS 150

ES-132179
778610

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78610

1. NAME OF DECEASED (Type or Print): Lottie Gales

2. DATE OF DEATH: 10-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 34 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Balto 11-04
D. STREET ADDRESS (If rural, give location): 1109 Tiffany Ct.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | July 31, 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Ga. | |

13. FATHER'S NAME: James Davis

14. MOTHER'S MAIDEN NAME: Rebecca

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|
| | |

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Vascular Accident | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive Arteriosclerotic Cardiovascular Disease | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-27, 19 49 *to* 10-2, 19 49 *that I last saw the deceased alive on* 10-2, 19 49 *and that death occurred at* 7:55 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. S. Rogers M.D. | 4940 EASTERN AVENUE | 10-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 5 1949 | Mt. Zion | Baltimore C. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Huntington Williams M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

9-30

ES-16263
G78611
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

13 G78611
Registered No.

1. NAME OF DECEASED (Type or Print): Andrew Street

2. DATE OF DEATH: 10-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto 10-02
D. STREET ADDRESS (If rural, give location): 820 Greenmount Avenue ( NO HOME)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Nov. 5, 1869 | 79 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Richard Street
14. MOTHER'S MAIDEN NAME: Sarah Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypertensive Cardiovascular Disease with Arteriosclerosis | |
| DUE TO (B) | Fibrous Myocardial Scarring | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Passive congestion of liver, lungs, spleen | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-21, 19 16 *to* 10-1, 19 49 *that I last saw the deceased alive on* 10-1, 19 49 *and that death occurred at* 8:00 m. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED: 10-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 4-49
24C. NAME OF CEMETERY OR CREMATORY: Old Brick Baptist
24D. LOCATION (City, town, or county) (State): Jarrettsville md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles E Kurtz Jarrettsville md
ADDRESS

VS 150

93D

G78612

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9030 G78612

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Edward Gregory Brooke — 2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-01; D. STREET ADDRESS (If rural, give location) 3906 Canterbury Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | widowed | Nov. 19, 1879 | 69 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mr. John Brooke

14. MOTHER'S MAIDEN NAME: Rachel Gregory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Dunbar Sanger ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio - respiratory failure - DUE TO Pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility DUE TO

(C) DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Fracture - neck right femur

INTERVAL BETWEEN ONSET AND DEATH:

CERTIFICATION APPROVED BY
R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3906 Canterbury Rd. Baltimore Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 27, 1949 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21F. HOW DID INJURY OCCUR? Pt. missed his chair - fell 12/1 to floor

22. *I hereby certify that I attended the deceased from* Oct. 1, 1949 *to* Oct. 1, 1949 *that I last saw the deceased alive on* Oct, 1949 *and that death occurred at* 5:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Mc Tumbler M. D. — 23B. ADDRESS: Union Memorial Hospital Baltimore Md — 23C. DATE SIGNED: 10/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) — 24B. DATE — 24C. NAME OF CEMETERY OR CREMATORY: David Ridge Cem. — 24D. LOCATION (City, town, or county) (State): Pikesville, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: John D. Mitchell & Sons — ADDRESS: 1900 Eutaw Place

VS 150

186a

G78613

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78613

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JULIA M. HOLBRUNER

2. DATE OF DEATH: 10/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 2807 White Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W | Married | 2/14/04 | 45 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George T. Usilton
14. MOTHER'S MAIDEN NAME: Frances Powell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Husband Charles W. Holbrunner ADDRESS: 2807 White Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Rheumatic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/12 1949 *to* 10/1 1949 *that I last saw the deceased alive on* 10/1 1949 *and that death occurred at* 9:50 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Blanke M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 10/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 4-49
24C. NAME OF CEMETERY OR CREMATORY: Church Hill
24D. LOCATION (City, town, or county) (State): Churchill Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

VS 150

951C

G78614

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

30 · G78614 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEONARD HOWARD — Col

2. DATE OF DEATH: 1 Oct 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto city

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): university Hospital

c. Length of stay in Baltimore: 15 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: md — B. COUNTY: 902 W. Fairmont ave

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 18-01

D. STREET ADDRESS (If rural, give location): 902 W. Fairmount ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | Sept. 4, 1914 | 35 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | ? | Calvert Co. Md | U. S. A. |

13. FATHER'S NAME: George Howard

14. MOTHER'S MAIDEN NAME: Annie Howard

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Annie Birdsall | 1014 W Fayette St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) meningitis, Staph

DUE TO

(B) acute Bacterial Endocarditis

DUE TO

(C) Kidney abscess

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Oct 1, 1949 to Oct 4, 1949 that I last saw the deceased alive on Oct 1, 1949, and that death occurred at 8:45 PM from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph Freeman M.D. M. D. | University Hospital | 2 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 6-49 | Eastern Chapel Co | Calvert Co md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Bentalou |

VS 150

91a

CERTIFICATE CORRECTED 10-11-49 ✓

G78615

BIRTH NO. 25-125058

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78615 Registered No.

1. NAME OF DECEASED (Type or Print): George Ordwein

2. DATE OF DEATH: 10-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 8 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 22-01
D. STREET ADDRESS (If rural, give location): 309 Sharp Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | July 30, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Pa | |

13. FATHER'S NAME: John Ordwein

14. MOTHER'S MAIDEN NAME: Clara Milletto

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | RECORDS*BALTO. CITY HOSPITALS | 4940 Eastern Aven |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-3 , 1948 *to* 10-2- , 1949, *that I last saw the deceased alive on* 10-2- 1949, *and that death occurred at* 8:40 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Organ M. D. | 4940 Eastern Avenue | 10-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/49 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3- 1949 | Huntington Williams, M.D. | Milburn & Son Inc | 1217 E. Baltimore St |

VS 150

13B

G78616

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78616

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET EMMA STEVENS

2. DATE OF DEATH: Oct 1 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2727 Eastern Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-03
D. STREET ADDRESS (If rural, give location): 2727 Eastern Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | July-14-1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at Home | Ohio | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Zenas Williams | Euphemia Clark |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Russell E. Stevens - 2727 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral Hemorrhage | 4 d. |
| DUE TO (B) | Myocarditis (Chronic) | .2 |
| DUE TO (C) | Hypertension | 2 |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 26, 1949 *to* Oct 1, 1949 *that I last saw the deceased alive on* Oct 1, 1949, *and that death occurred at* 7 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE / M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benj. Sanders | 2128 W. Monument | 10/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 4-49 | New Cathedral | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 1949 | Huntington Williams, M.D. | John J. Connolly | 418 Eastern Ave Balto. 24, Md. |

VS 150

93 D

G7861?

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

'51 G7861?

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES E. GIBSON

2. DATE OF DEATH: 9/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1136 Penna. Av

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1136 Penna. Av.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | 4/1/1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | Clothing | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William F. Gibson | Louisa Short |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Ella Jones(S) | 1136 Pa. Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5-14 19 49 *to* 9-29 19 49 *that I last saw the deceased alive on* 9-27 19 49 *and that death occurred at* 8 A m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Atwell Jones M. D. | 5-2-x Dolph St | 10-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/3/49 | Mt Auburn | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 3 - 1949 | Huntington Williams, M.D. | Chas H Gorsuch | 512 Cathedral St. |

469

78618 E926.0 ✓ G78618

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) JOSEPH EDWARD THOMPSON — N-853.4

2. DATE OF DEATH Oct. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN Baltimore, (If outside corporate limits, write RURAL and give township) Catonsville
D. STREET ADDRESS (If rural, give location) 764 Charring Cross Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Aug 23/22 | 27 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10B. KIND OF BUSINESS OR INDUSTRY Body Work
11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME Charles Thompson
14. MOTHER'S MAIDEN NAME —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) was WW I
16. SOCIAL SECURITY NO.
17. INFORMANT Elizabeth L. Thompson ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bullet wound of brain | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 764 Charring Cross Rd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 2, 1949 About 5:30 P.M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms (revolver)

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X] homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 30 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/6/49
24C. NAME OF CEMETERY OR CREMATORY Mt National
24D. LOCATION (City, town, or county) (State) Baeto City Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 4 1949
REGISTRAR'S SIGNATURE Washington Williams, M.D.
25. FUNERAL DIRECTOR MacNabb and Son. ADDRESS 164 c

VS 151

78619

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78619

1. NAME OF DECEASED (Type or Print) James Walter Johnson — JAMES JOHNSON

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH: Baltimore City, Maryland University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville 28
D. STREET ADDRESS (If rural, give location): 108 Shipley Ave.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 5, 1877
9. AGE (In years last birthday): 72 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carrol County, Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Julia Scoggins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?
17. INFORMANT: Harriett Johnson
ADDRESS: Catonsville, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 24 HRS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) POST OPERATIVE GASTRO ENTEROSTOMY — 72 HRS

DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) CARCINOMA OF STOMACH — 1 YR.

19A. DATE OF OPERATION: 9-28-49
19B. MAJOR FINDINGS OF OPERATION: CARCINOMA OF STOMACH
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13, 1949 *to* 10-1, 1949 *that I last saw the deceased alive on* 10-1, 1949 *and that death occurred at* 10 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: David Auld M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-4-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Gregory
24D. LOCATION (City, town, or county) (State): Cooksville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: F. C. Higinbothom
ADDRESS: Ellicott City, Md.

VS 150

46B

CERTIFICATE CORRECTED 10-19-49

G78620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. SELIG

Registered No. G78620

1. NAME OF DECEASED (Type or Print): Selig Miller

2. DATE OF DEATH: 10-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-01
D. STREET ADDRESS (If rural, give location): Alhambra Apts K 1 Lake Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 21, ~~1898~~ 1899
9. AGE (In years last birthday): 50
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Jewelery Business
10B. KIND OF BUSINESS OR INDUSTRY: Owner PAWNSHOP

11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harris D Miller

14. MOTHER'S MAIDEN NAME: Esther Lesser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr Archie Abramson
ADDRESS: 2440 Eutaw Place

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insuffic & Pulmonary Edema & Pulmonary infarction due to ASHD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2-49 19 *to* 10-2 19 49 *that I last saw the deceased alive on* 10-2 19 49 *and that death occurred at* 6 00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Katz M. D.

23B. ADDRESS: Sinai Hosp

23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct 4, 1949

24C. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4- 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North ave

VS 150

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93D

Med Exams Case
Released to Hospital

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78621

78621 B.C. 49-18462

1. NAME OF DECEASED (Type or Print): Winfred Witherspoon
2. DATE OF DEATH: Sept. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Harriet Lane
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-03
D. STREET ADDRESS (If rural, give location): 2322 Madison st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | | 5-27-49 | | 4 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: George Raikes
14. MOTHER'S MAIDEN NAME: Thea Witherspoon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hyperkalemia | |
| DUE TO | (B) Renal anuria | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) Dehydration & Acidosis | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Premature | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/27 *19*49 *to* 9/25 *19*49, *that I last saw the deceased alive on* 9/25 *19*49, *and that death occurred at* 8:25 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS JOHNS HOPKINS HOSPITAL | 23C. DATE SIGNED |
|---|---|---|
| | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Received [illegible] | |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: 159

VS 150 To be approved by Med Examiner Hospital Deposit

G78622

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

196 G78622 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANCIS J. KRECJI

2. DATE OF DEATH: October 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cold Spring Nursing Home

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 4024 Bellwood Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | single | May 8, 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| stock clerk | Sears-Roebuck | Baltimore, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Krecji | Mary Skrizan |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | | Jerome Minnick, 4024 Bellwood Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Osteogenic Sarcomatosis — Interval between onset and death: 6 Mos.

DUE TO

(B) Osteogenic Sarcoma - Lumbar Spine - 1 Mos.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* AUGUST 30, 19 49 *to* OCTOBER 2, 19 49, *that I last saw the deceased alive on* SEPT 30, 19 49, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Norman R. Kleiman M.D. | 3803 Edmondson Ave | Oct-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/49 | Oak Hill Cemetery | Horner's Lane, Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 150

55R

G78623

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78623

1. NAME OF DECEASED (Type or Print): Alice J. Wilkinson

2. DATE OF DEATH: Oct 2nd 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2018 Lecil Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2018 Lecil Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Aug 15th 1868
9. AGE (In years last birthday): 81 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Hammack
14. MOTHER'S MAIDEN NAME: Margaret Murray
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: Wm Wilkinson 2018 Lecil Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Anemia Pernicious | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | Rheumatic Sclerosis | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Large Fibroid Uterus. | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1942 *to* Oct 2nd, 1949, *that I last saw the deceased alive on* Oct 2nd, 1949, *and that death occurred at* 7:25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. Edw White M.D.
23B. ADDRESS: 3005 St Paul St.
23C. DATE SIGNED: 10-4-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 4th 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Windsor Mill Road

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Leak & Leak 1203 N. Patterson Park ave

VS 150 —

562

# CERTIFICATE CORRECTED 10-6-49

78624 — 51 — G78624

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): MRS TILLIE SLECHTA
2. DATE OF DEATH: 10-1-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): FULLERTON
D. STREET ADDRESS (If rural, give location): JOPPA Rd.
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, (WIDOWED), DIVORCED (Specify)
8. DATE OF BIRTH: 12-13-1874
9. AGE (In years last birthday): 74 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jan Pachaney
14. MOTHER'S MAIDEN NAME: Mary Bekarek
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: OTTO SLECHTA — ADDRESS: East Joppa Road

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis - Ca Stomach — Interval between onset and death: 1 month +
DUE TO
(B) anteriol blockage RT leg — 1 day.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9-26-49
19B. MAJOR FINDINGS OF OPERATION: Ca Stomach & Secondary Metastasis
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12, 1949 *to* 10-1, 1949, *that I last saw the deceased alive on* 10-1, 1949 *and that death occurred at* 7:30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Maryland Gen. Hosp.
23C. DATE SIGNED: 10-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/4/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
24D. LOCATION (City, town, or county) (State): Horner's Lane, Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street

VS 150

4613

Wyld Extension Corp. Release 1-1-52.

64.5 G78625

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. B.C. 49-18342 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Dorothy Mae Richardson

2. DATE OF DEATH: SEP 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland H.H.O.P.D.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 26 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-02

D. STREET ADDRESS (If rural, give location): 909 E Madison St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Single | 28 August 1949 | | 0 | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: James Richardson

14. MOTHER'S MAIDEN NAME: Dorothy ? P

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | | JOHNS HOPKINS HOSPITAL |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anuria

DUE TO

(B) Renal shut down

DUE TO

(C) Dehydration + Acidosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Vomiting + Diarrhea - Prostration

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

C. B. Fisher M. D.

CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-24-, 1949 *to* 9-24, 1949, *that I last saw the deceased alive on* 9-24-, 1949, *and that death occurred at* 7:15 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison Clark Spencer M.D. | JOHNS HOPKINS HOSPITAL | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | [illegible] | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | | |

VS 150

To be approved by Medical Examiner

119a

78626

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78626

1. NAME OF DECEASED (Type or Print) Adolph Lindner

2. DATE OF DEATH 10-2-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-28

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai

c. Length of stay in Baltimore 8 Yrs. Mos. Days

D STREET ADDRESS (If rural, give location) 7902 Allendale Road

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH | 9. AGE (In years last birthday) 72 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Not known

14. MOTHER'S MAIDEN NAME Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Jack Barth ADDRESS 7902 Allendale Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Edema
DUE TO
(B) A S & D
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchial Asthma

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2 1949 *to* 10-2 1949, *that I last saw the deceased alive on* 10-2 1949, *and that death occurred at* 12 25 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Leonard Kolb M. D.

23B. ADDRESS Sinai Hosp

23C. DATE SIGNED 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10-4-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 4 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewin Inc ADDRESS 2100 Eutaw Pl

VS 150

15665

927

78627

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4700 G78627

1. NAME OF DECEASED (Type or Print): MAX TATELBAUM

2. DATE OF DEATH: 4 October, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital / Baltimore
c. Length of stay in Baltimore: 40 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2655 Loyola Southway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | 2 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Grocer | Russia | |

13. FATHER'S NAME: Zackery
14. MOTHER'S MAIDEN NAME: Tema

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Celia Tatelbaum | 2655 Loyola So |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION WITH PULMONARY EDEMA
DUE TO
(B) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-4 1949 *to* 10-4, 1949, *that I last saw the deceased alive on* 10-4, 1949 *and that death occurred at* 335A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arnold H. Michael M. D. | Sinai Hospital / Balto. | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-4-49 | Hebrew Mt Carmel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | Jack Kesson Inc | 2100 Eutaw Pl |

VS 150

15761

92D

G78628

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78628

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lucious Wood

2. DATE OF DEATH: 10-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1417 E. Layfayette Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 9-19
D. STREET ADDRESS (If rural, give location): 1417 E. Layfayette Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | | 12-16-1882 | 66 | 9 | 16 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Richmond Co. Va. | U. S. |

13. FATHER'S NAME: William Wood

14. MOTHER'S MAIDEN NAME: Martha Palmer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 186-01-3564 | William W. Jackson | 1417 E. Layfayette Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemmorhage | 4-5 months |
| DUE TO (B) | Hypertension Cardio Vascular Renal Disease | |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 15, 1949 *to* Oct 2, 1949 *that I last saw the deceased alive on* Oct 2, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 803 N Fremont Ave | 10-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 10-6-49 | Ebenezer | Washaw Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 1949 | Huntington Williams, M.D. | Samuel W. Sullivan Jr | 1211 1011 N. Arlington Ave |

VS 150

G78629

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

446 Registered No. G78629

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Finn

2. DATE OF DEATH 10/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 620 S. Monroe St

c. Length of stay in Baltimore 50 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-03
D. STREET ADDRESS (If rural, give location) 620 S. Monroe St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | 5/24/1870 | 79 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired GALVANIZER
10B. KIND OF BUSINESS OR INDUSTRY General Electric
11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Finn
14. MOTHER'S MAIDEN NAME Honora Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs James V. Willis ADDRESS 620 S. Monroe St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio Sclerosis — 1 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 6 1948 *to* 10/2 1949 *that I last saw the deceased alive on* 10/2 1949 *and that death occurred at* 3:15 A m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. B. Wheeler M. D. | 1279 Williams St | 10/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/49 | New Cathedral Cem. | 4300 Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | John J. Cowan & Son | Pikesville |

VS 150

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G78630

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Form 1 G78630

BIRTH NO. (illegible)

Registered No.

1. NAME OF DECEASED (Type or Print) Francis M. Healy

2. DATE OF DEATH 10/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 327 S. Woodyear St

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-03
D. STREET ADDRESS (If rural, give location) 327 S. Woodyear St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | Married | 8/20/1898 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker

10B. KIND OF BUSINESS OR INDUSTRY B+O R.R.

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John Healy

14. MOTHER'S MAIDEN NAME Augusta Pflaum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Margaret M. Healy ADDRESS 327 S. Woodyear

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) none

DUE TO

(C) none

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/2, 19 49, to 19__, *that I last saw the deceased alive on* 10/2, 19 49 *and that death occurred at* 10 a m., *from the causes and on the date stated above.*

23A. SIGNATURE (illegible) M. D.

23B. ADDRESS 2550 Wilkens ave

23C. DATE SIGNED 10/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10/6/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore Natl Cem.

24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR OCT 4 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J Cowan & Son ADDRESS 918 Hollins St.

VS 150

94a

78631

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

5 60.3

G78631 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Magdalin Johnson Goldrich

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City, Maryland Hosp. for the Women of Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: Baltimore City.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City. 27-10

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 4724 Alhambra Avenue.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | Dec. 12, 1882 | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home Wife | — | Sweden | |

13. FATHER'S NAME: Carl Johnson

14. MOTHER'S MAIDEN NAME: Clara Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | | The Deceased | same. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute posterior Myocardial infarction | Approx. 24 hours. |
| DUE TO (B) | Pt. had repair of Ventral hernia Sept. 28, 1949. | |
| DUE TO (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Sept. 28, 1949. | Ventral hernia Post operative through Lower Rt LT Rectus incision | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No. | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Sept. 27, 1949, *to* Oct. 1, 1949, *that I last saw the deceased alive on* Sept. 30 Oct. 1949, *and that death occurred at* 11:05 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rosalba Robitti J. M.D. M. D. | Hosp. for the Women of Md. | Oct. 1, 1949. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-5-49 | ST. MARY'S GOVANI | BALTIMORE Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | John A. Moran | 3000 E Balt. St. |

VS 150

122a

G786.52

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G786.52

1. NAME OF DECEASED (Type or Print): John A. McKenna
2. DATE OF DEATH: 10-1-49
3. PLACE OF DEATH: Baltimore City, Maryland — BALTIMORE
   a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital (DOA)
   b. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MARYLAND
   B. COUNTY:
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 9-05
   D. STREET ADDRESS (If rural, give location): 502 E. NORTH Ave
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: MARCH 3 1893
9. AGE (In years last birthday): 56 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Court #2
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John A. J. McKENNA
14. MOTHER'S MAIDEN NAME: Agnes Doyle
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: MRS Julia Reed — ADDRESS: 502 E. NORTH Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer 2d, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 3 Oct. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-5-49
24C. NAME OF CEMETERY OR CREMATORY: New CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran — ADDRESS: 3100 E. Balt. St.

VS 151

94a

G78633

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78633

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IDA C. FREEDENBURG

2. DATE OF DEATH: Oct. 2, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3508 Copley Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3508 Copley Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Feb. 19, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Baltimore, Md. | |

13. FATHER'S NAME: - William Simering

14. MOTHER'S MAIDEN NAME: - Anna E. Hax

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mrs. W. H. Carman | 3508 Copley Rd. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrage | 9/29/49 |
| ANTECEDENT CAUSES | DUE TO (B) Chr. Myocarditis | 1947 |
| DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) Chr. Interstitial Nephritis | 1947 |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 15, 1949 *to* Oct. 2, 1949 *that I last saw the deceased alive on* Oct 2, 1949, *and that death occurred at* 2 40 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Brown, M. D. | 1631 W. North Ave. | 10/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

121a

78634

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78634

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM F. LILLY

2. DATE OF DEATH: October 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 644 W. Fayette treet

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Sept. 21, 1880 | 69 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| unemployed | | Baltimore, Md. | |

13. FATHER'S NAME: Francis A. Lilly

14. MOTHER'S MAIDEN NAME: Emma Cox

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 215-18-0866 | Mrs. Eva Hartlove | 1645 Smallwood St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Carl L Boyer M.D | ☐ / ☒ | 10-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/4/49 | London Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

921

8635 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78635

1. NAME OF DECEASED (Type or Print): Bernard Ponzel ROUZEE

2. DATE OF DEATH: 10-2-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3440 Belair Rd
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore MD 27-01
D. STREET ADDRESS (If rural, give location)

5. SEX: M.

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH: OCT. 12. 1901

9. AGE (In years last birthday): 47 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bdo. worker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): CHARLESTOWN W.VA.

12. CITIZEN OF WHAT COUNTRY? —

13. FATHER'S NAME: GEO ATWELL ROUZEE

14. MOTHER'S MAIDEN NAME: MARY E. FISHER.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 213-09-1576

17. INFORMANT: LORAN R ROUZEE ADDRESS 3440 Belair Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Circulatory failure

DUE TO

(B) Acute Myocardial Infarction

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2-49, 19—, *to* 10-2-49, 19—, *that I last saw the deceased alive on* 10-2-49, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William J. Holloway M.D.

23B. ADDRESS: University Hosp

23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: OCT 5. 49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

24D. LOCATION (City, town, or county) (State): BALTO. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 - 1949

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR: L. HEERMANN & SON ADDRESS 6067 HARFORD

VS. 150

47

94a

778536

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

16 Registered No. 778536

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ruth Clay

2. DATE OF DEATH 10/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 W. Hill Street

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2 W. Hill Street 22-01

5. SEX Female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 11/30/1890
9. AGE (In years last birthday) 58
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Royal
14. MOTHER'S MAIDEN NAME Sarah Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mary Hunt-920 Leadenhall Street ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 7 mo
DUE TO
(B) Hypertension Nephritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1949, to 10/2, 1949 *that I last saw the deceased alive on* 10/2, 1949, *and that death occurred at* 12 M., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 1122 See ✓
23C. DATE SIGNED 10/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/6/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary
24D. LOCATION (City, town, or county) (State) A.A.Co., Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 4 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR 1080 J. L. Brandon - Montgomery St ADDRESS

VS 150.

82a

G78637

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78637

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH HODEK
2. DATE OF DEATH: OCT. 3 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — BALTO. MD
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 713 N. ROSE ST.
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 9-02
D. STREET ADDRESS (If rural, give location): 713 N. ROSE ST.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: FEB. 8, 1890
9. AGE (In years last birthday): 59 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): CZECHOSLOVAKIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOSEPH BENDA
14. MOTHER'S MAIDEN NAME: ANNA STANEK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JAMES HODEK — ADDRESS: 713 N. ROSE ST

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: INSTANTANEOUS

DUE TO

(B) HYPERTENSIVE CARDIO-VASCULAR DISEASE — 2 YRS

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JULY 10 1949 to OCT. 3, 1949 that I last saw the deceased alive on OCT. 3 1949 and that death occurred at 8:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Henry J. Louska M. D.
23B. ADDRESS: 333 S. East Ave.
23C. DATE SIGNED: 10/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 7/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank Evach — ADDRESS: 900 N. Chester

VS 150

92D

Copies

BIRTH NO. G78638

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 Registered No. G78638

1. NAME OF DECEASED (Type or Print) Sylvester Birckett

2. DATE OF DEATH Sept 30 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Providence Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 1514 Division St

C. Length of stay in Baltimore 50 Years Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 335 N. Calhoune St

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 19-01

D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Colored | W | July 4 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Eastern Shore Md | U.S.A. |

13. FATHER'S NAME ? Birckett

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-05-5751

17. INFORMANT Thelma Weaver ADDRESS 335 N Calhoune St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| None | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-26, 1949, *to* 9-30, 1949 *that I last saw the deceased alive on* 9-30, 1949, *and that death occurred at* 6:25 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. McWilliams | 1131 Harlem Ave | 10/3/1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) / (State) |
|---|---|---|---|
| Burial | Oct 4 1949 | Mt Calvary Cemetery | A. R. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | R. Hurst Williams | 1515 McCulloh St |

VS 150

60

83a

78639

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903.5

Registered No. G78639

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Gluth — N-803.0

2. DATE OF DEATH Oct. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) City Hospitals
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-06
D. STREET ADDRESS (If rural, give location) 1333 S.Clinton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | Dec. 13,1879 | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs. Anna Reitz 1333 S.Clinton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fracture of skull & intra-cranial hemorrhage - | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): In front of 1345 S. Clinton Street 26/6
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 1, 1949 4 p. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell from chair striking head on pavement

22. *I certify that I took charge of the remains described above, held an* [illegible] *Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Emil L Beyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED Oct.2,1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE 10/5/49
24C. NAME OF CEMETERY OR CREMATORY: Mt.Carmel
24D. LOCATION (City, town, or county) (State): O'Donnell St.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

VS 151

186a

078640

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

163 Registered No. 078640

BIRTH NO.

1. NAME OF DECEASED (Type or Print): anthonny Bonkowski
2. DATE OF DEATH: Oct. 3-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 405 S. Maderia St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 1-05
c. Length of stay in Baltimore: 49 yrs (Yrs. Mos. Days)
D. STREET ADDRESS (If rural, give location): 405 S. Maderia St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboer
10B. KIND OF BUSINESS OR INDUSTRY: Canning
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: anthony Bonkowski
14. MOTHER'S MAIDEN NAME: anna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): L (If yes, give war or dates of service): L
16. SOCIAL SECURITY NO. 218-03-0002
17. INFORMANT: Mary Bonkowski ADDRESS 405 S Maderia St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malignancy of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 4 19 48 to Oct 2 19 49, that I last saw the deceased alive on Oct 2, 19 49, and that death occurred at 1:30 m., from the causes and on the date stated above.

23A. SIGNATURE: Milton L. Solomon M. D.
23B. ADDRESS: 129 S. Broadway
23C. DATE SIGNED: Oct 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 6-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS 2007 Eastern Ave

VS 150 (REV.)

47D

G78641

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 983 .5 G78641 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HAYWARD HILL N-803 ✓
2. DATE OF DEATH: September 30, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 641 Dover Street

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | May 30, 1900 | 49 (mp) | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Bar O.K.K. | Va. | |

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Alice Hill | 641 Dover St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture, skull
DUE TO
(B) Subdural hemorrhage
DUE TO
(C) Contusion, brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found in front of 131 Arch Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): September 30, 1949 7 p.m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Blunt force

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 10-1-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 4 1949 | Mt Calvary Cem | P. G. County Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Courtesy for Baltimore, Md.
25. FUNERAL DIRECTOR: Mrs. Robert G. Elliott Daniels
ADDRESS: 1129 N. Caroline St

VS 151

168

G78642

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

31 G78642 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bahlman, Hellie

2. DATE OF DEATH 10/1/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 23-03
D. STREET ADDRESS (If rural, give location) 55 E. Heath St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Fe | White | Divorced | 8/23/1887 | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| OWNER | TAVERN | MARYLAND | |

13. FATHER'S NAME George Tidings

14. MOTHER'S MAIDEN NAME Jane McDowell

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Joseph-Leo-Bahlman |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Esophageal obstruction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) mediastinal tumor.

DUE TO

(C) Chronic debilitation (own)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/27 *19*49 *to* 10/1/49 *19*__, *that I last saw the deceased alive on* 9/30 *19*49 *and that death occurred at* 2:45 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Fred Hawkins, M. D. | Franklin Square Hosp | 10/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Oct. 4, 1949 | New Cathedral | Old Fredrick Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 4- 1949 | Contingent for Williams, M.D. | KRAUSE FUNERAL HOME 1216 S. Charles |

VS 150 15671 57E 30 ST.

G78643

BIRTH NO. 49-19567

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1949

Registered No. G78643

1. NAME OF DECEASED (Type or Print): Wyne Chapple

2. DATE OF DEATH: 10-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1315 E Biddle St
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 10-01
D. STREET ADDRESS (If rural, give location): 1315 E. Biddle St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | Single | 9-4-49 | | 28 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Chapple
14. MOTHER'S MAIDEN NAME: Bertina Stanley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bertina Stanley ADDRESS: 1315 E Biddle St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cholera Infantum
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 10 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/30/49 to 10/3/49, that I last saw the deceased alive on 10/3/49, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

23A. SIGNATURE: Chas R. Blake, M. D.
23B. ADDRESS: 1603 N. Caroline
23C. DATE SIGNED: 10-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-4-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county): (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders
ADDRESS: 1412 E. Preston St 119a

VS 150

G78644 ✓ G78644

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 10

BIRTH NO. OPelia

1. NAME OF DECEASED (Type or Print): Opelia McClure

2. DATE OF DEATH: OCT 2- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1619 Ellsworth St
D. STREET ADDRESS (If rural, give location): Baltimore Md 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | 7-24-07 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Va | |

13. FATHER'S NAME: Claw Johnson

14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Inflammatory carcinoma, tett breast, cerebral metastasis | 6 mos |
| DUE TO (B) | | |
| ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 1949 | Carcinoma, lt breast | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-30- 1949 *to* 10-2, 1949, *that I last saw the deceased alive on* 10-2, 1949, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David E. Rogen M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL / CREMATION / REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-6-49 | Mt Calvary Cem | A. A. Co Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949

REGISTRAR'S SIGNATURE: Curtis Williams, M.D.

25. FUNERAL DIRECTOR: Leyner Sanders ADDRESS: 1412 E. Preston St

VS 150

G78645

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78645

1. NAME OF DECEASED (Type or Print) Harold C. Grubbs

2. DATE OF DEATH Oct 2nd 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-06

D. STREET ADDRESS (If rural, give location) 715 N. 36th Street

c. Length of stay in Baltimore 53 Years Yrs. Mos. Days

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH May 2-1889

9. AGE (In years last birthday) 60 If Under 1 Year Months Days If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of job, even if retired) Elec Mech. Baltimore Transit Retired 4 yrs

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Scott Grubbs

14. MOTHER'S MAIDEN NAME Mary Jane McEuen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-10-0072

17. INFORMANT Mrs. Bettie E. Grubbs ADDRESS 715 N. 36th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronco-pneumonia DUE TO

(B) Arteriosclerotic Cardio Vascular disease DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 19 48, to Oct 2, 19 49, *that I last saw the deceased alive on* Oct 2, 19 49, *and that death occurred at* 5:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE William E. Kelbrich M. D.

23B. ADDRESS 3006 Roland Ave

23C. DATE SIGNED Oct 3 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 5-1949

24C. NAME OF CEMETERY OR CREMATORY Druid Ridge

24D. LOCATION (City, town or county) (State) Pikesville, Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 4- 1949

REGISTRAR'S SIGNATURE Lexington Williams M.D.

25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 362 Falls Road

VS 150

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G78646

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

416 Registered No. G78646

1. NAME OF DECEASED (Type or Print): Della N. Whaley

2. DATE OF DEATH: 10/3/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11
D. STREET ADDRESS (If rural, give location): 3431 Keswick Rd. 13-06

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Mem. Hospital

c. Length of stay in Baltimore: 41 yrs (Yrs. Mos. Days)

5. SEX: F
6. COLOR or RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: May 9, 1908
9. AGE (In years last birthday): 41 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hsewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Herman N. Grimm
14. MOTHER'S MAIDEN NAME: Ella Calder Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Franklin M. Whaley
ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Left sided Heart Failure
DUE TO
(B) Rheumatic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/30, 1949 *to* 10/3, 1949, *that I last saw the deceased alive on* 10/3, 1949, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Coe M.D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 10/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 6-1949
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 363 Falls Rd

VS 150

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G78647

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4-20-1 Registered No. G78647

1. NAME OF DECEASED (Type or Print): Andrew Wagner

2. DATE OF DEATH: Mon. Oct. 3 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 Clarkson St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1604 Clarkson St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Aug. 21-1885 | 64 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None YARDMASTER
10B. KIND OF BUSINESS OR INDUSTRY: SHIPBUILDING
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Wagner
14. MOTHER'S MAIDEN NAME: Christina HOFF
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 212-03-2488
17. INFORMANT: Mrs. Minnie Meisser ADDRESS: (Same)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Occlusion | 2 days |
| ANTECEDENT CAUSES | DUE TO (B) Hypertensive cardio vascular renal disease | 2 |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Chronic Atrophic bronchitis | ? |

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 10/1, 1949, *to* 10/3, 1949, *that I last saw the deceased alive on* 10/2, 1949, *and that death occurred at* 3:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Deitel M. D.
23B. ADDRESS: 1226 Hanover St
23C. DATE SIGNED: 10/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 6, 1949
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Balto Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Howard Evans ADDRESS: 1400 S. Charles St. Balto 30 Md.

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G78648

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 92.5

Registered No. G78648

BIRTH NO.

N-861

1. NAME OF DECEASED (Type or Print) GEORGE THOMPSON (THOMAS) C.

2. DATE OF DEATH October 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-05
D. STREET ADDRESS (If rural, give location) 101 N. Dallas Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Single | May.4.1916 | 33 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Longshoreman | | Balto. Md. | U.S.A. |

13. FATHER'S NAME
George Thompson

14. MOTHER'S MAIDEN NAME
Josemay Horsey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Ware 2 | 208-12-7915 | Willis Telp | 322 Diamond St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab Wound of aorta

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) tavern

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Caroline St. & Fairmont Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY October 1, 1949 4.00p m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Sharp instrument

22 *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE Earl L. Royer M.D

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR

23C. DATE SIGNED Oct. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 5. 1949

24C. NAME OF CEMETERY OR CREMATORY Balto. Nat. Cem.

24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 4 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D

25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantly Ave.

167

G78649 ✓ 3 2 G78649

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Porter Gibson

2. DATE OF DEATH Oct. 2. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. city
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-01
D. STREET ADDRESS (If rural, give location) 109 Welcome alley

c. Length of stay in Baltimore 12 yrs. (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Col. | Single | Nov. 15. 1881 | 67 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | On Vessel | Gibson N. C. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jim Gibson | Harriett Parker |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Gertrude Nichols | Stanhope N.C. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypostatic pneumonia | Undet |
| DUE TO (B) | Cerebral thrombosis | Undet |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ✓ NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/1/49, 19__, to 10/2/49, 19__, *that I last saw the deceased alive on* 10/2/49, 19__ *and that death occurred at* 12 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lewis H. Logan M. D. | Provident Hosp. | 10/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 6-49 | Green Pond | Green Pond N. C. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantley ave

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G78650

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

760 · 0 G78650

BIRTH NO. B.C. 49-25397 Registered No.

1. NAME OF DECEASED (Type or Print) DARIUS PARHAM

2. DATE OF DEATH 10-4-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1234 N Arguith St

5. SEX M

6. COLOR OR RACE B

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 11/16/48

9. AGE (In years last birthday) 10 Months 10 Days

If under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Harry Jones

14. MOTHER'S MAIDEN NAME Nellie Parham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) subarachnoid hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) unknown cause — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: diarrhea

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-29, 1949 *to* 10-4, 1949, *that I last saw the deceased alive on* 10-3, 1949, *and that death occurred at* 1.55 a m., *from the causes and on the date stated above.*

23A. SIGNATURE E. J. Broadders M.D.

23B. ADDRESS University Hospital

23C. DATE SIGNED 10-4

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10-6-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem

24D. LOCATION (City, town, or county) (State) Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 4 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Elroy O. Wilson

ADDRESS 1000 Brantly

VS 150

119a

Dr. Battaglia
5329 Belair

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78651

1. NAME OF DECEASED (Type or Print): Joseph L. Morrow

2. DATE OF DEATH: Oct. 2-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1426 E. Federal St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1426 E. Federal St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | July 4-1886 | 63 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lithographer
10B. KIND OF BUSINESS OR INDUSTRY: Store Loan Rapid
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212-01-2596
17. INFORMANT: Mrs Jean Larkin ADDRESS: 734 E. North

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arterio Cardio Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: uncertain
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/6, 19 47, to 9/27, 19 47, *that I last saw the deceased alive on* 9/27, 19 47, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. J. Battaglia M. D. | 5329 Belair Rd | 10/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 10-4-49 | London Park | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949
REGISTRAR'S SIGNATURE: Evington Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford Rd.

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G78652

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78652

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Domingo Taboada

2. DATE OF DEATH: October 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Park Drive & 31st St., Baltimore 11, Maryland
c. Length of stay in Baltimore: Yrs. 256 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 21 Columbia Place

5. SEX: Male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 11, 1887
9. AGE (In years last birthday): 61 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10B. KIND OF BUSINESS OR INDUSTRY: Seafaring
11. BIRTHPLACE (State or foreign country): Spain
12. CITIZEN OF WHAT COUNTRY?: Spain

13. FATHER'S NAME: Frank Taboada
14. MOTHER'S MAIDEN NAME: Mary (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Records, US Marine Hospital, Balto., Md. ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchopneumonia, lung abscess | 2 weeks duration |
| DUE TO | aspiration | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Squamous cell carcinoma of larynx. | Duration 1 year, 8 months |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 20, 1949 *to* October 3, 1949 *that I last saw the deceased alive on* Oct. 3, 1949 *and that death occurred at* 8:20 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson
John L. Wilson, Medical Director M. D.
23B. ADDRESS: US Marine Hospital, Balto., Md.
23C. DATE SIGNED: 10-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 4/49
24C. NAME OF CEMETERY OR CREMATORY: Brooklin N. York
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John M. Weber
ADDRESS: 401 S. Chester St. Balto. 31 Md.

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G78653

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78653

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Louis Plack

2. DATE OF DEATH: October 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Park Drive & 31st St., Baltimore 11, Md.

c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3805 Ridgewood Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June 3, 1889 | 60 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Railway Mail Clerk | U. S. Gov't. | Maryland (Baltimore) | USA |

13. FATHER'S NAME: William Plack

14. MOTHER'S MAIDEN NAME: Elizabeth Gibb

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | Unknown | Records, | US Marine Hospital, Balto., Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hodgkin's Disease with polyserous, | Duration more than 5 months. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) lung, and multiple lymph node involvement. Arteriosclerosis of kidney with cortical cysts. | Duration unknown. |
| | (C) Arteriosclerosis, aorta. | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Sept. 10, 1949 *to* October 2, 1949 *that I last saw the deceased alive on* Oct. 2, 1949, *and that death occurred at* 12:20 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John I. Wilson, Medical Director M. D. | US Marine Hospital, Balto., Md. | 10-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/49 | Mt. Olivet Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4- | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78654

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Pascarell

2. DATE OF DEATH: OCT 4 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Halstead 7

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY: Fayette
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brownsville
D. STREET ADDRESS (If rural, give location): Box 620

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | 6-2-1908 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Pa. | |

13. FATHER'S NAME: Nick Journitz

14. MOTHER'S MAIDEN NAME: Theresa ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial aneurysm.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Postoperative cerebral infarction.

DUE TO

(C) Coarctation aorta.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) F
(B) 30 hrs.
(C)

19A. DATE OF OPERATION: 14 Oct 49

19B. MAJOR FINDINGS OF OPERATION: Large intracranial aneurysm removed

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-18-, 1949 *to* 10-4-, 1949 *that I last saw the deceased alive on* 10-4-, 1949, *and that death occurred at* 5:14 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert G. Fisher M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 4 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/7/49.

24C. NAME OF CEMETERY OR CREMATORY: BROWNSVILLE

24D. LOCATION (City, town, or county) (State): BROWNSVILLE Pa

DATE RECEIVED BY LOCAL REGISTRAR: OCT 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Nelson Co Inc 1217 Eutaw St

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George J. Brauer

2. DATE OF DEATH: 10/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 429 North East Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-10
D. STREET ADDRESS (If rural, give location): 429 North East Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | May 24, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | Soap Mfg. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: John J. Brauer

14. MOTHER'S MAIDEN NAME: Ann Elizabeth Luken

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | 216-05-5681 | Mrs. Annie Brauer, 429 N. East Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

(B) Chronic coronary sclerosis — 10 years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Generalized arterio sclerosis — 12 yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

W F Fisher M. D.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If outside City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| none m. | ☐ | |

22. *I hereby certify that I attended the deceased from* — 19 —, *to* 10/2, 1949, *that I last saw the deceased alive on* — 19 —, *and that death occurred at* 7.40 *—m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Maurice Feldman Jr M. D. | 817 St Paul st | 10/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/5/49 | Parkwood Cem. | Parkville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 4 - 1949 | Huntington Williams, M.D. | C. V. Lemmon. 4611 Park Heights Ave. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Bernard MULLEN

2. DATE OF DEATH 10-2-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 15-12

c. Length of stay in Baltimore 70 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3930 Reisterstown Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | M | Apr. 7, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cabinet maker | Funiture Mfg. | Balto. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Mullen | Annie McCarthy |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 214-03-7214 | Self | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs.

DUE TO

(B) Arteriosclerotic Heart Disease ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-15-49 | Gastric Ulcer | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | none | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-2, 1949, *to* 10-2, 1949, *that I last saw the deceased alive on* 10-2, 1949, *and that death occurred at* 8:04 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ruth Bleier M. D. | Sinai Hospital, Balto | 10-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/5/49 | Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4- 1949 | Huntington Williams, M.D. | L. V. Lemmon | 4611 Park Heights Ave. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78657 — BIRTH NO. — Registered No. G78657

1. NAME OF DECEASED (Type or Print): Anne Wheeler

2. DATE OF DEATH: Oct. 4, 1949

3. PLACE OF DEATH: Baltimore City, Maryland — Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 12-01
D STREET ADDRESS (If rural, give location): 40th St. & Stony Run Lane

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Garden Apartments 40th St. & Stony Run Lane

c. Length of stay in Baltimore: 15 (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | about | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | ------- | Ontario, Canada | |

13. FATHER'S NAME: Thomas Long

14. MOTHER'S MAIDEN NAME: Nancy Eaton

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. J. Albert Speed | 700 Benston Pl |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Edema due to | 2 Hrs. |
| ANTECEDENT CAUSES | DUE TO (B) arteriosclerosis, Essential Hypertension | 20 years |
| DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | DUE TO Coronary Thrombosis. | 1 day |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | (C) Diaphragmatic Hernia, osteoporosis Diverticulitis | several years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 1945, 19__, *to* Oct 4, 1949 *that I last saw the deceased alive on* Sept 20, 1949, *and that death occurred at* APP. 7 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph J. Hills, M. D. | 18 E Eager St Balto | Oct 4, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/8/49 | Calvary, St. Paul, Minn | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 4 1949 | Huntington Williams, M.D. | H. W. Meares and Son | 803 N. Calvert St. |

VS 150

122a

G78658

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78658

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Peter Samaras — PETER G SAMARAS

2. DATE OF DEATH 10/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St. Agnes
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hosp.
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE W Va
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weirton
D. STREET ADDRESS (If rural, give location) Pennsylvania Ave

5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 12/ /1892 yrs.
9. AGE (In years last birthday) 56 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ger. Greece
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME George Samaras
14. MOTHER'S MAIDEN NAME Deeb
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT SCHWERTA FUNERAL HOME WEIRTON W VA.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) OSTEOGENIC SARCOMA ILEUM C METASTASIS
DUE TO
(B) TO SPLEEN & LUNG
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 9/29/49
19B. MAJOR FINDINGS OF OPERATION ORCHIDECTOMY (ATROPHIC TESTIS)
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/8, 1949 *to* 10/4, 1949 *that I last saw the deceased alive on* 10/4, 1949 *and that death occurred at* 12:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE John F. Shaw M. D.
23B. ADDRESS St. Agnes Hosp
23C. DATE SIGNED 10/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/5/49
24C. NAME OF CEMETERY OR CREMATORY CHAPEL HILLS MEMORIAL GARDENS
24D. LOCATION (City, Town, or county) WEIRTON (State) W VA.

DATE RECEIVED BY LOCAL REGISTRAR OCT 5- 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR William J Dickner & Sons
ADDRESS North & Annapolis

VS 150

9FE-29

46E

11

78659

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

446 Registered No. 078659

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Chester Eley

2. DATE OF DEATH: Oct. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 220 N. Monroe St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 220 N. Monroe St.

C. Length of stay in Baltimore: 33 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore; D. STREET ADDRESS (If rural, give location): 220 N. Monroe St. 20-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | June 14, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor | College | Virginia | U. S. A. |

13. FATHER'S NAME: ——— Eley

14. MOTHER'S MAIDEN NAME: ? Crockers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Julia Eley ADDRESS: 220 N. Monroe Sreet

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)

(A) Nephrosclerosis (uremia) — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ——— DUE TO

(C) ———

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 wks

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/16 19 49 *to* 10/2, 19 49 *that I last saw the deceased alive on* 10/1, 19 49, *and that death occurred at* 8 15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] — 23B. ADDRESS: RAYMER BROWNE, M. D. 1200 EAST MADISON ST. BALTIMORE 5, MD. — 23C. DATE SIGNED: 10-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 10-6-49 | 24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park | 24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: M. O. Frances A. Hensley | ADDRESS: W. Balto

VS 150 7-40 91

131a

G78660

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78660

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret E. Roy Evans

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1215 Winchester Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1215 Winchester St. 16-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | July 14, 1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | U. S. A. |

13. FATHER'S NAME: Clarence E. Roy

14. MOTHER'S MAIDEN NAME: Mary E. Gaskins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Arthur R. Evans Sr. ADDRESS: 1215 Winchester

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Coronary Occlusion | 1 day |
| DUE TO (B) | Arteriosclerosis | 2 mos |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-2, 1949 *to* 10-1, 1949 *that I last saw the deceased alive on* 10-1, 1949, *and that death occurred at* 10:00 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Gladys M. D. | 1543 Penna. Ave | 10/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-5-49 | Arbutus Mem. Park | Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | Huntington Williams, M.D. | Wm. Frances J. Hensley | 678 W. Baltimore St |

VS 190 ...

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078661

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 078661

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Abe Posner

2. DATE OF DEATH: 10-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-17
D. STREET ADDRESS (If rural, give location): 2503 Keyworth Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2503 Keyworth Ave

C. Length of stay in Baltimore: 1½ Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 83 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Peddler

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: David

14. MOTHER'S MAIDEN NAME: Esther

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rachel Posner ADDRESS: 2503 Keyworth

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cancer of Colon

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Aug 30 to Oct 4, 1949, that I last saw the deceased alive on 10/4, 1949 and that death occurred 12-Am., from the causes and on the date stated above.

23A. SIGNATURE: M. Rhodes M. D.

23B. ADDRESS: 2225 Linden

23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): removal

24B. DATE: 10-5-49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State): Buffalo N. Y.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 - 1949

REGISTRAR'S SIGNATURE: Tunstall for Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis

ADDRESS: 2100 Eutaw Pl.

VS 150 2-52 79 46E

8662

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E-903.0 810 Registered No. 78612

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RACHAEL HOSCHER

2. DATE OF DEATH: 10-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2652 Park Heights Terrace

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 13

c. Length of stay in Baltimore: Yrs. 50 Mos. Days

D. STREET ADDRESS (If rural, give location): 2652 Park Heights Terrace

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | | 93 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Moser | Hannah |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Jacob Bornstein | 2653 Park Heights Terr |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 dy

DUE TO (B) Cardiac Factual Arteriosclerosis — 4 yrs

DUE TO (C) Fracture of left hip closed - open full

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

Earl Ryan M.D.

CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | home | 2652 Park Heights Avenue 15/13 |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| September 9, 1949 ?p.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Slipped on waxed floor and fell |

22. *I hereby certify that I attended the deceased from* 9/9, 19 49 *to* Oct 5, 19 49, *that I last saw the deceased alive on* Oct 2, 19 49, *and that death occurred at* 5:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis I. Schwartz M.D. | 3700 Park Heights Ave | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-5-49 | United Hebrew | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

186a

G78653

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78653

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY FLINKMAN

2. DATE OF DEATH: 10/4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Mt Sinai Nursing Home

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-17 — D. STREET ADDRESS (If rural, give location) 5028 Pembridge Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MT. SINAI NURSING HOME 4613 Park Heights Ave

c. Length of stay in Baltimore: 58 (Yrs. / Mos. / Days)

5. SEX: Male — 6. COLOR OR RACE: White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married — 8. DATE OF BIRTH: Nov. 25 1887 — 9. AGE (In years last birthday): 61 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — 10B. KIND OF BUSINESS OR INDUSTRY: Vest Maker — 11. BIRTHPLACE (State or foreign country): Russia — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David — 14. MOTHER'S MAIDEN NAME: Rose Bader

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO — 17. INFORMANT: Anna Flinkman — ADDRESS: 5028 Pembridge

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — (INTERVAL BETWEEN ONSET AND DEATH) Sudden

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis — many years

DUE TO

(C) Chronic Pulmonary Emphysema — many years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: no — 19B. MAJOR FINDINGS OF OPERATION: None — 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): None m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* Oct 3 1949 *to* Oct 4 1949, *that I last saw the deceased alive on* Oct 3 1949, *and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph MosTwill M. D. — 23B. ADDRESS: 806 Eutaw Place — 23C. DATE SIGNED: 10/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 10-5-49 — 24C. NAME OF CEMETERY OR CREMATORY: Hebrew Young men — 24D. LOCATION (City, town, or county) / (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Alex Lewin — ADDRESS: 2100 Eutaw Pl

VS 150

Ralph Mostwill

94a

G78664

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 98 r. 4 G78664 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LINWOOD MATTHEWS — N-861.r

2. DATE OF DEATH October 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
South Baltimore General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1451 Ward Street 21-0 r

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | single | June 22, 1930 | 19 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Linwood Matthews,

14. MOTHER'S MAIDEN NAME Cora Turpin.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Linwood Matthews ADDRESS 1402 Ward St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stab wound of heart — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) park

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Bush St. entrance to Carroll Park

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 2, 1949 1.15p.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? sharp instrument

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE Paul L. Reyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED October 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 6, 1949

24C. NAME OF CEMETERY OR CREMATORY M. E. Lutheran Cem.

24D. LOCATION (City, town, or county) Balto. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 5 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Miss Nellie R. Williams

ADDRESS 922 N. Gilmor St.

VS 151

167

G78665

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

581 0

Registered No. G78665

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Wright Small.

2. DATE OF DEATH: 10-1-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1032 N. Payson St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1032 N. Payson St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1032 N. Payson St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md
D. STREET ADDRESS (If rural, give location): 1032 N. Payson St 11 - 4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | C | married | may 6, 1917 | 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md | |

13. FATHER'S NAME: Alexander Wright.

14. MOTHER'S MAIDEN NAME: Carrie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Freddie Small. ADDRESS: 1032 N. Payson St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cirrhosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Secondary lues

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 1948 *to* 10/1, 1949 *that I last saw the deceased alive on* 10/1, 1949 *and that death occurred at* 8:30 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Aborofsky M. D. M. D. | 6018 Monroe St. | 10/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 5 1949 | Balto National | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | [illegible] for Williams, M.D. | Wm Watts Williams | 329 W Lexington St |

VS 150

209

78666 BALTIMORE CITY HEALTH DEPARTMENT 43 G78666

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ADDIE JEFFERSON

2. DATE OF DEATH: Sept 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balts. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1004 S. Hanover St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1004 S. Hanover St. 22-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH
9. AGE (In years last birthday): 78 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balts. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Jefferson
14. MOTHER'S MAIDEN NAME: Catherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Axel Hansen ADDRESS: 1004 Hanover St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis, chronic with — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO Myocardial degeneration
(B) Hypertensive Cardio — ?
DUE TO Vascular Disease
Arteriosclerotic
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30, 1949, *to* 9-30, 1949 *that I last saw the deceased alive on* 9-30, 1949, *and that death occurred at* 4:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John P. Ulrich Jr M. D.
23B. ADDRESS: 1227 Wash. Blv'd
23C. DATE SIGNED: 10-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 5-1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

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7866.7

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): David Bivings

2. DATE OF DEATH: Sept. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Av
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2015 McCulloh St 14 03

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 7, 1889
9. AGE (In years last birthday): 59 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Sugar Refinery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William
14. MOTHER'S MAIDEN NAME: Classie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: B.C.H. Records ADDRESS: 4940 Eastern Av.

MEDICAL CERTIFICATION

18. J73.0

CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Broncho pneumonia~~

DUE TO

(B) Pneumococcic lobar pneumonia ~~tuberculosis~~ (over)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Silicosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-28 1949 *to* 9-30 1949, *that I last saw the deceased alive on* 9-30 1949 *and that death occurred at* 5.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Av
23C. DATE SIGNED: 10-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-5-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. H. Cooper
ADDRESS: 512 Gaywood Av

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G78668 M.S.131913 G78668

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wilhelmina Smith

2. DATE OF DEATH: Sept. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Av
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 574 Baker St. Z 17 14-03

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 2 1884
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Deceased
14. MOTHER'S MAIDEN NAME: Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: B.C.H. Records-4940 Eastern Av. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriolar nephrosclerosis

DUE TO

(C) Hypertensive arteriosclerostic cardio vascular disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-16, 1949 *to* 9-30, 1949, *that I last saw the deceased alive on* 9-30, 1949, *and that death occurred at* 3.20 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Rogers, M. D.
23B. ADDRESS: 4940 Eastern Av
23C. DATE SIGNED: 10-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 5-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas H. Cosden ADDRESS: 512 Lanvale St

VS 150

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978669

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 978669

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie C Mullen

2. DATE OF DEATH: Oct. 3. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1227 Valley St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1227 Valley St

c. Length of stay in Baltimore: Life — Yrs. / Mos. / Days: 10 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widower | Dec 6. | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore | U. S. |

13. FATHER'S NAME: George McC Williams

14. MOTHER'S MAIDEN NAME: Isabelle Hawkins

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | No | Jane Mullen 1227 Valley St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B) congestive failure
DUE TO
(C) auricular fibrillation

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO · Hypertension, arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) ? ; (B) 1 yr. ; (C) ? ; ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug, 1948, *to* 3 Oct, 1949 *that I last saw the deceased alive on* 1 Oct, 1949, *and that death occurred at* 4:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Silverfield M. D. | 714 E. Preston St | 5 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 7. 1949 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 5 - 1949 | Huntington Williams, M.D. | Rida Wiedefeld 900 E. Biddle St |

VS 150

94a

G78670

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 53 G78670

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry Barclay

2. DATE OF DEATH: 10-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 651 W. Franklin St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN Balto. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 651 W. Franklin St. 17-01

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| M | C | WIDOWER | 2-1-1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Military Police | EDGC WOOD ARSENAL | TALLADEGA = ALABAMA | U. S. A. |

13. FATHER'S NAME: Joe Barclay

14. MOTHER'S MAIDEN NAME: Caroline Hardy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WORLD WAR I | | Annie Mae Gunn | 607 W. FRANKLIN ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | metastatic Carcinoma liver, spine urinary bladder, adrenalia | 6 months+ |
| DUE TO (B) | adenocarcinoma of cecum | 6 months+ |
| DUE TO (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: arteriosclerotic heart Disease not Known

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 4.28.49 - Joh Howard | Carcinoma cecum & metastasis to liver, bladder spine | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4.6.49, 19__, *to* 10.1.49, 19__, *that I last saw the deceased alive on* 9.28.49, 19__, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James M. Pair M. D. | 400 N. Carrollton Ave | 10.3.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-6-49 | National Cemetery | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | Huntington Williams, M.D. | William A. Jackson | 916 Penna Ave. |

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78671 ✓ E 903.° 078671

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herbert Lee Norfleet — N-8-1-0

2. DATE OF DEATH: October 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Park Dr. & 31st St., Balto., Md.

c. Length of stay in Baltimore: Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 210 E. Lake Avenue

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 20, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Dealer | Own Lumber Business Havana, Cuba | Virginia | USA |

13. FATHER'S NAME: Alexander Wilson Norfleet

14. MOTHER'S MAIDEN NAME: Indianna Edwards

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Spanish-American | --- | Records, US Marine Hospital | Balto., Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral arteriosclerosis and thrombosis. | Duration unknown |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Hypertrophy of prostate with obstruction. | Duration unknown |
| (C) | Fracture left humerus | 25 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

CERTIFICATION APPROVED BY
R S Fisher M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | In home | 210 E. Lake Ave., Balto., Md. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Sept. 10- 1949 m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Inside home Fall (Slipped and fell to floor) |

22. *I hereby certify that I attended the deceased from* Sept. 17, 1949 *to* Oct. 4, 1949 *that I last saw the deceased alive on* Oct. 4 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert V. Hazlett, Jr. SA Surgeon U.S.P.H.S. | US Marine Hospital, Balto., Md. | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10/5/49 | Poplar Spring Cem. | Franklin, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5- 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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G78672

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78672

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE BAUER, Jr.

2. DATE OF DEATH: Oct. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2012 N. Longwood St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2012 N. Longwood St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | April 18, 1884 | 65 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Police Lieutenant | Balto. Police Dept. | Baltimore, Md. | |

13. FATHER'S NAME: George Bauer, Sr.

14. MOTHER'S MAIDEN NAME: Elizabeth Bonnett

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Elsie Bauer | 2012 N. Longwood St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Chronic myocardial degeneration with cardiac hypertrophy and congestive failure | 1 year. |
| DUE TO (B) | generalized arteriosclerosis by progression | many years. |
| DUE TO (C) | Cerebral Hemorrhage with Hemiplegia. | 5 months |
| (C) | | |

19A. DATE OF OPERATION: None.

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1, 1949 *to* Oct 3, 1949 *that I last saw the deceased alive on* Oct 2, 1949 *and that death occurred at* 6.30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Michel M. D.

23B. ADDRESS: 1015 Poplar Grove St

23C. DATE SIGNED: Oct 5 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/5/49 | Loudon Park Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS

ADDRESS: Balto., Md.

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G78673

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20 | G78673 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Reginald M. H. Banbury

2. DATE OF DEATH Oct. 4/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 906 Belgian Ave.

C. Length of stay in Baltimore 17 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 906 Belgian Ave. 27-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 31, 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Vice President | Calvert Fire Ins. Co. | New York | |

13. FATHER'S NAME Reginald M. H. Banbury

14. MOTHER'S MAIDEN NAME Anna E. Montgomery

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Brother) ADDRESS |
|---|---|---|
| | 212 07 9178 | Winston Banbury, 2635 Meisel St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Embolism | 3 minutes |
| DUE TO | | |
| (B) | Coronary Thrombosis | 4 days |
| DUE TO | | |
| (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1-49 19 *, to* Oct 4-49, 19 *, that I last saw the deceased alive on* Oct 4-49, 19 *, and that death occurred at* 5A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| + H Herrmann M. D. | 1710 Eutaw Pl | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 7/49 | Meadowridge Memorial Pk. | Dorsey, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 5-1949 | Huntington Williams, M.D. | Harry H. Nitsche | 4101 Edmondson Ave. |

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G78674 ✓ G78674

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print) Hands, Oliver H.

2. DATE OF DEATH 10-4-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1705 Cole St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| m | w | Married | March 14, 1919 | 30 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cabinet Maker | B. & O. R.R. | Balto. Md. | |

13. FATHER'S NAME Oliver R. Hands

14. MOTHER'S MAIDEN NAME Emma M. Hall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 214 01 6558 | Mrs. Marie M. Hands | 1705 Cole St. |

## MEDICAL CERTIFICATION

18. 237 X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac edema

DUE TO

(B) Brain tumor

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-3-49 | Brain tumor left temporal | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 10-4, 1949, *that I last saw the deceased alive on* 10-4, 1949, *and that death occurred at* 2A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Nichols M.D. | Univ. Hosp. | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 7/49 | Baltimore National | 5501 Frederick Rd. Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | Huntington Williams, M.D. | Harry A. Kirkpatrick | 2101 Edmondson Ave. |

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Dr. Hart G78675

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78675

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leona C. Mertz

2. DATE OF DEATH: Oct. 3-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE: Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-03

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 646 E. 35th St.

D. STREET ADDRESS (If rural, give location): 646 East 35th Street

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | July 28-1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Washington, D.C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Miersch | Elizabeth Kiel |

| 15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Charles C. Mertz | 646 E. 35th. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Congestive Heart Failure | 7 days |
| DUE TO (B) | Cardio Vascular Lesion | 8 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| No operation | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 26, 1949, *to* Oct 3, 1949, *that I last saw the deceased alive on* Oct 3, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M Bowen and Hood M. D. | 2200 Garrison Blvd | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-6-49 | Loudon Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5305 Harford |

VS 150

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G78676 BALTIMORE CITY HEALTH DEPARTMENT G78676

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John C. Botzer 306382

2. DATE OF DEATH OCT 4 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Osler - 6

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 1006 E. North Ave. 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| male | White | married | 6-21-84 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Time card clerk | Hospital | Md. | |

13. FATHER'S NAME John C. Botzer

14. MOTHER'S MAIDEN NAME Louise Geise

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | NONE- | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ? pulmonary embolism

DUE TO

(C) Renal insufficiency

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-13-, 1949 *to* 10-4-, 1949 *that I last saw the deceased alive on* 10-4-, 1949 *and that death occurred at* 11.30P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William H. Wintermitz M. D. | JOHNS HOPKINS HOSPITAL | Oct 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE Oct 7, 1949 Oct 5 1949 | 24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY | 24D. LOCATION (City, town, or county) (State) CITY |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 5 1949 | Huntington Williams, M.D. | WIEDEFELD & SON. |

VS 150 26 92 937 GREENMOUNT AVE & 22ND ST.

G78677

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 4

G78677

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Hayden Lewis Hann | 2. DATE OF DEATH: Oct 5th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 332 E. LAFAYETTE AVE
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 17-05
D. STREET ADDRESS (If rural, give location): 332 E. LAFAYETTE AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | MARRIED | 1881 | 68 | - | - | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AUTO. MECHANIC | GARAGE | MARYLAND MIDDLEBORO | |

13. FATHER'S NAME: (?)
14. MOTHER'S MAIDEN NAME: (?)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | MRS. MARTHA HANN | 332 E. LAFAYETTE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: William G Helfrich M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: Oct 5-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-7-49 | HAWK'S CHURCH CEM. | REKMAR - WOODSBORO MD. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 5 - 1949
REGISTRAR'S SIGNATURE: Deputy for Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON - ADDRESS

VS 151

332-84 94a GREENMOUNT & 22ND ST.

G78678

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 977.0

Registered No. G78678

1. NAME OF DECEASED (Type or Print): CHARLES SCHULLER — N-862.2

2. DATE OF DEATH: October 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — Towson
D. STREET ADDRESS (If rural, give location): 20 W. Chesapeak Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | MARRIED | Aug. 27, 1887 | 62 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CARETAKER | RADIO STATION | BALTIMORE, MARYLAND | USA |

13. FATHER'S NAME: HENRY SCHULLER

14. MOTHER'S MAIDEN NAME: MARY SCHULLER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 212-10-9837 | PARKS SCHULLER | |

## MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple stab wounds of chest — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 20 W. Chesapeak Avenue |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 4, 1949 5.00a.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Sharp instrument |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| J. A. Schneider M.D. | | Oct. 4, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Oct. 7 1949 | PROSPECT HILL CEM. | TOWSON, MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 5 1949 | Huntington Williams, MD | JOHN BURNS' SONS, | TOWSON, MD. |

VS 151 94457

1647

G78679

106477

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

63

G78679

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Arthur Green

2. DATE OF DEATH: OCT 3 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Bal-2 Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY 16-02
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) 936 N. Strieker St
D. STREET ADDRESS (If rural, give location) Baltimore Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 3-4-1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | RESTAURANT | Virginia | U.S.a. |

13. FATHER'S NAME: William Green

14. MOTHER'S MAIDEN NAME: Betty Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | [illegible] | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Tracheal obstruction | 9 mos. |
| DUE TO | (B) Carcinoma of lung | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-27- 1949 *to* 10-3 1949, *that I last saw the deceased alive on* 10-3 1949, *and that death occurred at* 7 49 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip J. Nagley M. D. | JOHNS HOPKINS HOSPITAL | Oct. 4, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Shipped | Oct. 5, 1949 | | Harpers Ferry W. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 - 1949 | [illegible] Washington Williams, M.D. | Mrs. Katie K. Williams | 322 N. Schroeder St. |

VS 150

72071

471

G78680

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78680 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Costello.

2. DATE OF DEATH: Oct. 5 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Penn. [illegible]
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Powellsville.
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 12-26-24 | 24 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | — | D. C. | |

13. FATHER'S NAME: Teddie Costello

14. MOTHER'S MAIDEN NAME: Bessie Casper

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | ? acute rheumatic cardiovascular | |
| DUE TO | disease | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 3 1949 *to* Oct 5, 1949 *that I last saw the deceased alive on* Oct. 5, 1949, *and that death occurred at* 1:45 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W. Dandy M. D. | JOHNS HOPKINS HOSPITAL | Oct 6 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10-6-49 | Alexis Cemetery | Alexis, N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Huntington Williams, M.D. | Beretta Bros | Alexis N C |

VS 150

93c by Lyle R. Fuller

G78681

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

154.0 G78681

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Wayne Dennis

2. DATE OF DEATH: OCT 5 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buchanan
D. STREET ADDRESS (If rural, give location): Rt. 2 Box 30

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 10-19-43
9. AGE (In years last birthday): 5 6 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Dennis
14. MOTHER'S MAIDEN NAME: Lavernia Bannester

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Post-operative Hemorrhage | 30 min. |
| DUE TO (B) | Thrombectomy for Thrombosis of Fallopian | Complicated |
| DUE TO (C) | | |

19A. DATE OF OPERATION: 10/5/49
19B. MAJOR FINDINGS OF OPERATION: Thrombosis of Fallopian
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1 19 49 *to* 10-5 19 49, *that I last saw the deceased alive on* 10-5 19 49 *and that death occurred at* 4:20 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE: Richard L. Griffith M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: OCT 8-1949
24C. NAME OF CEMETERY OR CREMATORY: Buchanan Cem.
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. L. Williams — ADDRESS:

VS 150

157E

G78682
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G78682
Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES SOWER'S
2. DATE OF DEATH: 4 OCT 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Home 27 N Carey
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1007 S. Charles St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years—last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | M. | Mar. 2-1888 | 61 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Sowers
14. MOTHER'S MAIDEN NAME: Barbara Krell
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT: LeRoy T. Dixon ADDRESS: 407 E. Cross ST

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriosclerotic and hypertensive cardio-vascular disease.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 Sept, 1949, *to* 4 Oct, 1949 *that I last saw the deceased alive on* 4 Oct, 1949 *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil H. Henning Jr M. D.
23B. ADDRESS: 4580 Edmondson Ave
23C. DATE SIGNED: 4 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/8/49
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1212 St Paul St

VS 150

937

CERTIFICATE CORRECTED 10-20-49

G78683

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78683

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary D Lademacher

2. DATE OF DEATH 10/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Maryland Gen. Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Unknown Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex #21
D. STREET ADDRESS (If rural, give location) 300 George Judge Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | May 1st, 1871 Unknown | 79 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Boston, Mass. | U.S.A. |

13. FATHER'S NAME Joe Knowles Joseph W. Knowles

14. MOTHER'S MAIDEN NAME Kate McKiwi Anna McKeever

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Herman A. Lademacher ADDRESS 300 Judge Ave George Essex 21

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Pancreas. — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Cholecystitis with Stones — Unknown

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* oct 1, 1949, *to* oct 5, 1949, *that I last saw the deceased alive on* oct 4, 1949, *and that death occurred at* 3:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. L. Mark M. D. | Maryland General Hospital | 10/5/49 |

| 24A. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10, 8, 49 | Dulaney | Eastern Ave. Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6- 1949 | Lucy Washington Williams, M.D. | Tom Cook Bros. | 217 St. Paul St. |

VS 150

469

G78684

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78684

BIRTH NO. B.C. 49-21090

1. NAME OF DECEASED (Type or Print): Baby Yacorissi

2. DATE OF DEATH: 10-4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Maryland, Balt. Md.

c. Length of stay in Baltimore: Yrs. 8 hrs 38 min Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 11 12-07
D STREET ADDRESS (If rural, give location): 423 W. 23rd Street.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 10-3-'49 | | | | 6 | 38 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Maryland | USA |

13. FATHER'S NAME: John Hannon

14. MOTHER'S MAIDEN NAME: Anna Marie Yacorizzi

| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | none | Anna Marie Yacorissi | 423 W. 23rd St. Balt. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Intrauterine anoxia | 4 days |
| | DUE TO | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) 1. Prematurity | — |
| | 2. Maternal — Placenta previa & hemorrhage | 4 days |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 3, 1949, *to* Oct 4, 1949, *that I last saw the deceased alive on* 10-4 1949, *and that death occurred at* 5:35 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Anna Jogelberg M. D. | Hosp. for Women of Maryland | Oct 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/6/49 | St. Peters | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Huntington Williams M.D. | Wm. Work Jrs | 1217 St. Paul St. |

VS 150

159

G78685

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450.0 G78685 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillian E. Smith

2. DATE OF DEATH: 10/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1101 Eutaw Pl.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 10-02
D STREET ADDRESS (If rural, give location): 1101 Eutaw Pl

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 4/22/1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | Own Home | Balto Md. | |

13. FATHER'S NAME: John S. Hoffman

14. MOTHER'S MAIDEN NAME: [illegible]

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. C. Simons | 2100 Calow Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Myocardial failure — ?

DUE TO

(C) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 1949 *to* Oct 4, 1949, *that I last saw the deceased alive on* Oct 4, 1949, *and that death occurred at* 12:45 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J. Klimes M. D. | 7623 E. Monument St | 10/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/7/49 | Holy Redeemer | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Huntington Williams, M.D. | [illegible] | [illegible] St. Paul St. |

VS 150

97

G78686

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78686

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sophia Friedman

2. DATE OF DEATH: Oct. 4th. 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland — Emarsonian Aprts.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE same — B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 13-01

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore: Yrs. Lifetime, Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | june 27th. 1867 | 82 | 3 | 21 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Moses Strauss

14. MOTHER'S MAIDEN NAME: Caroline ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: Mr. Melvin Friedman, Emersonian Aprt.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary occlusion | 15 minutes |
| DUE TO | | |
| (B) | Coronary artery sclerosis symptoms | 3 years |
| DUE TO | | |
| (C) | Generalized arteriosclerosis symptoms | 9 years |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feby 5th, 1940 *to* Oct. 4th, 1949 *that I last saw the deceased alive on* Oct 4th, 1949, *and that death occurred at* 1.25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis P. Hamburger M. D. — 23B. ADDRESS: 1207 Eutaw Place — 23C. DATE SIGNED: 1207

24A. BURIAL, CREMATION, REMOVAL (Specify) — 24B. DATE: Oct. 6th. 1949 — 24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship . . — 24D. LOCATION (City, town, or county) (State): Balto. md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 - 1949 — REGISTRAR'S SIGNATURE: Huntington Williams M.D. — 25. FUNERAL DIRECTOR: Harold Friedman — ADDRESS: 1902 Eutaw Pl.

VS 150

94a

G78687

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

120.0 G78687

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ROSE FRIEDENBERG

2. DATE OF DEATH: 10/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL of BALTO.

c. Length of stay in Baltimore: 50 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 29-16
D. STREET ADDRESS (If rural, give location): 4527 Pimlico Road

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1878
9. AGE (In years last birthday): 71 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Abraham Isaac Epstein

14. MOTHER'S MAIDEN NAME: Yetta ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Bernard Scheff ADDRESS: 4527 Pimlico Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardiac Infarction with Pulmonary Edema
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30 1949 *to* 10-4 1949 *that I last saw the deceased alive on* 10-4 1949 *and that death occurred at* 6:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Conrad H. Michael M. D.
23B. ADDRESS: Sinai Hospital of Baltimore
23C. DATE SIGNED: 11-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 6, 1949
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1128 W North Ave

VS 150

93D

G78688

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

71

G78688

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Louise C. White

2. DATE OF DEATH: 10/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 906 S. Baylis St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-09
D. STREET ADDRESS (If rural, give location): 906 S. Baylis St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/14/1915
9. AGE (In years last birthday): 34 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carmine D. Ambrosia
14. MOTHER'S MAIDEN NAME: Mary Tatta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Clarence P. White ADDRESS: 906 S. Baylis St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastric Leiomyosarcoma

DUE TO

(B) Carcinoma of Cervix

DUE TO

(C) Generalized Carcinomatosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 19[illegible] *to* 9/27, 19[illegible] *that I last saw the deceased alive on* 9/27, 1949, *and that death occurred at* 2 20 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Christian F. Richter M. D.
23B. ADDRESS: 11 W. Biddle St.
23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/7/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Lilly & Zeiler, Inc. 403 S. Wolfe St. (31)

VS 150

48a

RUDROFF

G78689

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78689

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John G Rudroff

2. DATE OF DEATH Oct 5, 1949

3. PLACE OF DEATH: A Baltimore City, Maryland 5919 Belair Rd

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
5919 Belair Road
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.
D. STREET ADDRESS (If rural, give location) 26-01

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 65 Yrs. Mos. Days

| 6. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | married | April 2 1879 | 70 | 5 | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Blacksmith | With. Gas Co. | Germany | U S A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John G Rudroff Sr Germany | Unknown Germany |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 212-05-7104 | Mrs Marguerite Rudroff | 5919 Belair Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 3 hrs. |
| DUE TO (B) | Hypertensive Cardiovascular Disease many years. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 29, 1949, *to* Oct 5, 1949, *that I last saw the deceased alive on* Oct 4, 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark R. English M. D. | 5713 Belair Rd. | Oct 5 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 7 - 1949 | Baltimore Cemetery | North Ave & Rose St Balto 13 Md |

DATE RECEIVED BY LOCAL REGISTRAR OCT 6 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Albert L Wilkes

ADDRESS 1606 N Chester St

VS 150

302 59

937

G78690

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

340.3

Registered No. G78690

BIRTH NO. 6 C. M-12896

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Ronald Fidler | 2. DATE OF DEATH: October 5, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore |
| c. Length of stay in Baltimore: Yrs. 4 Mos. 11 Days 10 | D. STREET ADDRESS (If rural, give location): 410 W. 25th. St. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | single | Nov. 15, 1944 | 4 YRS | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles E. Fidler | Mildred Sinclair |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Charles E. Fidler | 410 W 25th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Meningitis, type undetermined | 12 hrs. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 5, 1949 *to* Oct 5, 1949 *that I last saw the deceased alive on* Oct 5, 1949 *and that death occurred at* 6:52 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Donald Ewey M. D. | U.M.H. - 33rd & Guilford | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/7/49 | St Mary's | Hampden |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 - 1949 | Huntington Williams, M.D. | James E. Ebenswetter Jr. 3-15-17 | Catonsville |

VS 150

81a

G78691

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. G78691

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry E. Bell

2. DATE OF DEATH: Oct. 4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 523 N. Streeper St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 7-01
D. STREET ADDRESS (If rural, give location): 523 N. Streeper St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June 11-1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | Sale | Balto. Md. | |

13. FATHER'S NAME: John W. Bell

14. MOTHER'S MAIDEN NAME: Olivia McGonigal

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Elizabeth Zahn | 523 N. Streeper St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary Oedema | 4 days |
| DUE TO (B) | Cardio-Vascular Hypertension Disease | 5 years. |
| DUE TO (C) | Arteriosclerosis | 5 yrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* January 6, 1947, *to* Oct. 4, 1949, *that I last saw the deceased alive on* Oct. 3, 1949, *and that death occurred at* 10:45 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Michael J. Daniel, M. D. | 4636 Belair Road | 10/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 7 '49 | Balto. Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 [illegible] | Huntington Williams, M.D. | John L. Miller | 2334 Jefferson St. |

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92D

G78692

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78692

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martha Louise Millbach
2. DATE OF DEATH: OCT 5 - 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE N.Y. B. COUNTY
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): E. Syracuse
c. Length of stay in Baltimore: 0 Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 1142 Yates St
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Child
8. DATE OF BIRTH: 7-21-46
9. AGE (In years last birthday): 3 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Floyd Millbach
14. MOTHER'S MAIDEN NAME: Katherine Herman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO
(B) Febrology of Fallot — INTERVAL BETWEEN ONSET AND DEATH: congenital
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10/3/49
19B. MAJOR FINDINGS OF OPERATION: Febrology of Fallot
20. AUTOPSY? YES X NO
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2-1949 *to* 10-5-1949, *that I last saw the deceased alive on* 10-5-1949, *and that death occurred at* 7:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard T. Kaufman, M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 9/49
24C. NAME OF CEMETERY OR CREMATORY: Syracuse
24D. LOCATION (City, town, or county) (State): Syracuse. New York

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Miller
ADDRESS: 2334 Jefferson St

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157E

G78693

BIRTH NO. 49-22115

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

774 Registered No. G78693

1. NAME OF DECEASED (Type or Print): Baby girl Womble

2. DATE OF DEATH: 10/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. — Mos. — Days 2 days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 224 S. Woodwell, Gray Manor

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | Single | 10/4/49 | — | — | 2 | — | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| new born | — | Maryland | U.S.A. |

13. FATHER'S NAME: Worth Womble

14. MOTHER'S MAIDEN NAME: Arline Lejarre

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Arline Womble | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Respiratory Failure
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/5, 1949, *to* 10/6, 1949, *that I last saw the deceased alive on* 10/6 1949, *and that death occurred at* 3:05 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas B. Turner M. D. | Mercy Hospital | 10/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 6, 1949 | Sacred Heart | Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Huntington Williams, M.D. | Roland L. Fisher | Dundalk Md. |

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G78694

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78694

1. NAME OF DECEASED (Type or Print): Ada Mary Andrews

2. DATE OF DEATH: October 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 6000 Bellona Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home

c. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6327 Charles Street Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | | Abt. 83 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Schoolteacher, retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Henry Andrews

14. MOTHER'S MAIDEN NAME: Alice Ann Gott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Leroy L. Andrews ADDRESS: 6327 Charles St. Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: about 2 yrs

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 19 49 *to* Oct 4, 19 49 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter Dubitt M. D.

23B. ADDRESS: 2220 Garrison Boulevard

23C. DATE SIGNED: Oct 5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: Oct. 6, 1949

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell & Sons, Inc. ADDRESS: 1900 Eutaw Place

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G78695

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78695

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BLANCHE ANDERSON
2. DATE OF DEATH: 10/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 20-07
D. STREET ADDRESS (If rural, give location): 413 Lyndhurst St #29

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Aug 23 '70
9. AGE (In years last birthday): 79
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Anderson
14. MOTHER'S MAIDEN NAME: Catherine Garrott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mildred A. Jones ADDRESS: 106 W. Monument Balto

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident

DUE TO

(B) Hypertension - Arteriosclerotic

DUE TO Cardiovascular Disease

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Coronary Thrombosis

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9/25, 1949 *to* 10/4, 1949, *that I last saw the deceased alive on* 10/4 1949 *and that death occurred at* 4:20 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Black M.D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 10/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 6/49
24C. NAME OF CEMETERY OR CREMATORY: All Hallows
24D. LOCATION (City or County): Davidsonville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John W. Mitchell Sons ADDRESS: 1900 Eutaw Place

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G78696

BALTIMORE CITY HEALTH DEPARTMENT 19 3

# CERTIFICATE OF DEATH

G78696

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) [redacted] ISABELLA B. CASPARI

2. DATE OF DEATH 10-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-13
D. STREET ADDRESS (If rural, give location) 701 W. Lake Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | Sept. 14, 1886 | 63 62 | - | - | - | - |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Berron
14. MOTHER'S MAIDEN NAME Elizabeth F. Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Husband ADDRESS (same)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Neurogenic Sarcoma (Rt. leg) — INTERVAL BETWEEN ONSET AND DEATH (A) 2-4 months
DUE TO ? pulmonary metastasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 29 1949 *to* October 5, 1949, *that I last saw the deceased alive on* Oct. 5, 1949, *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard R. Beach M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24B. DATE Oct 6. 1949
24C. NAME OF CEMETERY OR CREMATORY London Park Cemy
24D. LOCATION (City, town, or county) (State) 3801 Fred. Ave.

DATE RECEIVED BY LOCAL REGISTRAR OCT 6 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR John O. Mitchell & Sons ADDRESS 1900 Eutaw Place

VS 150

55E

Correct age is especially important. Physicians, please write the cause of death very plainly.

G78697

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

G78697

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JACOB KANTOR.

2. DATE OF DEATH: 10/5/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen Hosp.

C. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 15-03
D. STREET ADDRESS (If rural, give location): 1514 N. Pulaski St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | | 90 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Junk Business

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jenny

14. MOTHER'S MAIDEN NAME: Yunette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Emma Kantor ADDRESS 1514 N Pulaski

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Arteriosclerotic Cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10-20 yrs.

DUE TO

CERTIFICATION APPROVED BY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO B R Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C) Fractured Femur, Rt. — 14 days

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 15 N. Pulaski Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): September 22, 1949 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Slipped and fell to floor (Inside home)

22. *I hereby certify that I attended the deceased from* 9/27 19 YY *to* 10/5 19 YY, *that I last saw the deceased alive on* 10/5 19 YY, *and that death occurred at* 1 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Sher M. D.

23B. ADDRESS: West Balto Gen Hosp

23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10-6-49

24C. NAME OF CEMETERY OR CREMATORY: Rosedale

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6-19

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc

ADDRESS: 2100 Gutard Pl

VS 150

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186a

G78698

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78698

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BLUMENTHAL, BERNARD

2. DATE OF DEATH: 10-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-09
D. STREET ADDRESS (If rural, give location): 2307 Callow Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| College Student | | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Oliver | Mary |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Oliver Blumenthal | 2307 Callow |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia and Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Post - tobotomy

DUE TO

(C) Catatonic schizophrenia

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-10-49 | cut prefrontal nerve fibers | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-1, 1949 *to* 10-5, 1949 *that I last saw the deceased alive on* 10-5, 1949 *and that death occurred at* 2:45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert K. Davis M.D. | Mon. Hospital | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-6-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Huntington Williams M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

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107

G78699 G78699

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

181 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOUIS LASHINSKY

2. DATE OF DEATH: 6 OCT 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore: 26 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. VA.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Charleston
D. STREET ADDRESS (If rural, give location): 431 Virginia St East

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Junk - Merchant | Junk | Russia | |

13. FATHER'S NAME: not Known

14. MOTHER'S MAIDEN NAME: Goldie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Rachael Lashinsky | Charleston W Va |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ANURIA -
DUE TO
(B) INFILTRATIVE CANCER of BLADDER
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June - 1949 | Ca of bladder | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10 Sept, 1949 *to* 6 OCT, 1949, *that I last saw the deceased alive on* 6 OCT, 1949, *and that death occurred at* 12:55 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis Scherlis M.D. | Sinai Hospital | 6 OCT 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10-6-49 | | Charleston W. Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Huntington Williams, MD | Jack Lewis Inc | 2100 Eutaw Pl |

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52B

G78700

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 3 ✓

Registered No. G78700

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Pauline M. Duerr**

2. DATE OF DEATH **Oct. 4, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 15-06
D. STREET ADDRESS (If rural, give location) **1820 Ashburton St.,**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1820 Ashburton St.,**

c. Length of stay in Baltimore **87** Yrs. ___ Mos. ___ Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **Female** | **White** | **Widowed** | **Nov. 30, 1861** | **87** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **House-work** | **At Home** | **Germany** | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| **Jacob Eberhardt** | **Not Known** |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | **none** | **Mrs. Teresa Moran** | **526 E. 20th St.,** |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) **Cerebral thrombosis** | **1 week** |
| DUE TO | | |
| ANTECEDENT CAUSES | (B) **Arteriosclerosis** | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* **November**, 1946 *to* **October**, 1949, *that I last saw the deceased alive on* **10/4**, 1949, *and that death occurred at* **1015 P.M.** *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **Louis R. Mazer M.D.** M. D. | **4335 Park Heights Ave** | **10/5/49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **10-7-49** | **New Cathedral** | **Baltimore, Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| **OCT 6- 1949** | **Huntington Williams, MD** | **G. Howard Strong** | **3207 W. North Ave.,** |

VS 150

83B

G78701

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78701

1. NAME OF DECEASED (Type or Print): Patrick Owens

2. DATE OF DEATH: 10-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

C. Length of stay in Baltimore: 25 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 2401 Aisquith Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 11-6-1886 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard | Md. Penitentiary | Ireland | |

13. FATHER'S NAME: Pat Owens

14. MOTHER'S MAIDEN NAME: Mary Rafferty

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Patrick J Owens | 2401 Aisquith Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Monocytic Leukemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-1 1949 *to* 10-4 1949, *that I last saw the deceased alive on* 10-4 1949, *and that death occurred at* 6.45 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Y. Smith Jr M. D. | Univ. Hosp. | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 7, 1949 | Mount Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | [illegible] | John A. Moran | 3000 E. Balto St Balto. 24. Md. |

VS 150

74a

G78702

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. Bl. 49-00305 **CERTIFICATE OF DEATH** H9 Registered No. G78702

1. NAME OF DECEASED (Type or Print) Smith, Lloyd

2. DATE OF DEATH Oct 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland M-

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 8 Days Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-04

D. STREET ADDRESS (If rural, give location) 5-334 Wright Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Jan 3, 1949 | 0 | 9 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Smith

14. MOTHER'S MAIDEN NAME Charlotte Kahler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? cardiac failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) pneumonitis DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-27 1949, to 10-4 1949, *that I last saw the deceased alive on* 10-4, 1949 *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE David Joseph M.D.

23B. ADDRESS Mercy Hosp.

23C. DATE SIGNED 10/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 7, 1949

24C. NAME OF CEMETERY OR CREMATORY Baltimore Cems

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 6 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John A. Moran

ADDRESS 3000 E. Balto St Balto. Md.

VS 150

109a

G78703

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

94

G78703

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): FRANK ROZANOWICZ

2. DATE OF DEATH: October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 637 S. Montford Avenue

C. Length of stay in Baltimore: 65 Yrs. Mos. Ds.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-03
D. STREET ADDRESS (If rural, give location): 637 S. Montford Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 11/25/1863 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman - Ret. | | Poland | USA |

13. FATHER'S NAME: ---------- Rozanowicz

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Lillian Boracki, ADDRESS: 637 S. Montford Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senility
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 26, 1949, *to* Oct. 5, 1949, *that I last saw the deceased alive on* Oct. 5, 1949, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sigmund R. Nowak M. D. | 23B ADDRESS: 408 S. Patterson Park Ave. | 23C DATE SIGNED: 10/5/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/7/49 | St. Stanislaus | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: M. F. Sadowski & Sons, ADDRESS: 1808 Eastern Avenue

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162 R

G78704

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

474 Registered No.

G78704

BIRTH NO. B.C. 49-07780

1. NAME OF DECEASED (Type or Print): Louisa Marchiano

2. DATE OF DEATH: OCT 3 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-02
D. STREET ADDRESS (If rural, give location): 931 N. Luzerne ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | 4-13-49 | | 6 | 20 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Joseph Marchiano

14. MOTHER'S MAIDEN NAME: May Salvo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Laryngo-tracheitis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-30 1949 *to* 10-3 1949, *that I last saw the deceased alive on* 10-3 1949, *and that death occurred at* 900 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison C. Spence M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 5. 1949 | Oak Lawn, | Eastern ave |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949

REGISTRAR'S SIGNATURE: Remington Williams, M.D.

25. FUNERAL DIRECTOR: Wendell J. Hoppel ADDRESS

106c

VS 150

G78705 Shird ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 57 1.0

Registered No. G78705

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Gunning Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 40m
(e) Length of stay in Baltimore (yrs., mos., or days) 11 months

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

**3 (a) FULL NAME** Timothy Lawrence Shird ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | Colored | single |

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5 1946

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | 11 | 29 | — hr. — min. |

9. Birthplace Baltimore County. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Louis Franklin Minton
13. Birthplace Georgia.

MOTHER
14. Maiden Name Irene Eleanor Jobes
15 Birthplace Md.

16 (a) Informant Mother
(b) Address 720 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Stayton
(b) Address 638 N. Gilmor St Washington Williams, Md

19 (a) OCT 6 (Date received by Registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** Oct 4 1947, at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4, 9:45 AM 1947, to Oct 4 12:25 PM 1947 and that I last saw h. alive on Oct 4 1947, 12 M.

**Immediate cause of death**
Collapse of medullary respiratory center
Due to shock dehydration & anuria
Due to diabetes mellitus & probably diabetic acidosis
Other Conditions Obesity
Malignancy - lymphoblastic
(Include pregnancy within 3 months of death)

**Duration**
12 days.

Date of operation none
Major findings of operation: none
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. A. Graham, Jr. M. D.
Address Gunning Hosp. Date signed 10/6/47.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 159

119a

078706 513 568

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

41 6 078706 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Janie Johnson

2. DATE OF DEATH: Oct. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Osl & F med-

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 2322 Stockton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Married | 11-5-1913 | 35 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Robert Johnson

14. MOTHER'S MAIDEN NAME: G. Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema, Pulmonary infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

(B) Rheumatic heart disease — 25 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-29-, 1949 *to* 10-3-, 1949, *that I last saw the deceased alive on* 10-3-, 1949 *and that death occurred at* 11 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: David E. Hogen M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: 10/7/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6- 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Joseph A. Lively

ADDRESS: 661 W. Barre St

VS 150

95B

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78707

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G78707

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTHA ELLA WATERS

2. DATE OF DEATH: Oct. 4th, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1308 Division St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1308 Division St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1308 Division St

c. Length of stay in Baltimore — Yrs. Life; Mos.; Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widowed | 6/4/1892 | 57 | 4 / 0 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Domestic | Balto. Md. | U.S.A. |

13. FATHER'S NAME: James Dennis

14. MOTHER'S MAIDEN NAME: Louisa Payne

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | David Waters Jr. | 527 Lanvale St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO

(B) Arteriosclerosis — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 3 Hrs.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1949 *to* Oct 4, 1949 *that I last saw the deceased alive on* Oct 4, 1949 *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles F. Wood M. D. | 23B. ADDRESS: 8 E. Preston St Baltimore Md | 23C. DATE SIGNED: 10-6-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/7/49 | Mt. Zion Cemetery | Balto. County, Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS: Charles G. Cooper-512 N. Carrollton Av.

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G78708

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78708

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Lonnie Taylor

2. DATE OF DEATH Oct 1 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1108 Leadenhall St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 23-01
D. STREET ADDRESS (If rural, give location) 1108 Leadenhall St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Col | — | | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | — | Balto | |

13. FATHER'S NAME James Hughes

14. MOTHER'S MAIDEN NAME Hattie Hollowaway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT James Parker ADDRESS 1108 Leadenhall St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B) Hypertension & Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr - 10 1949 *to* Oct 1 1949 *that I last saw the deceased alive on* Oct 1 1949 *and that death occurred at* 10 11 *m., from the causes and on the date stated above.*

23A. SIGNATURE Dana Trauscher M. D.

23B. ADDRESS 122 W. Lee

23C. DATE SIGNED 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct 6 49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem

24D. LOCATION (City, town, or county) (State) A.A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 6 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Isaac L Brown Son ADDRESS 108 W Montgomery St

VS 150

93D

G78709 — 232018

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 3 — Registered No. G78709

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Susie Ford

2. DATE OF DEATH: 10-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 18-01
D. STREET ADDRESS (If rural, give location): 205 N. AMITY STREET.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | April 4, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Taylor Fuller

14. MOTHER'S MAIDEN NAME: Mary Warfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: RECORDS BALTO CITY HOSPITALS ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Luetic Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Secondary to strangulated hernia

Bowel Obstruction--~~Appendicitis~~

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-20-49 | Bowel Obstruction Bowel Resection | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-20, 1949 *to* 10-4, 1949, *that I last saw the deceased alive on* 10-4, 1949, *and that death occurred at* 7:35 p.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Rogers M. D. | 4940 Eastern Avenue | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-8-1949 | N.W. Auburn Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 3244 Edmondson Ave |

122B

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78710
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78710

1. NAME OF DECEASED (Type or Print): HOLLAND JONES sml

2. DATE OF DEATH: October 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 633 Sarah Ann St

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 1889
9. AGE (In years last birthday): 60 Sml
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboren
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UnKnown
14. MOTHER'S MAIDEN NAME: UnKnown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: William Mayfield ADDRESS: 636 Sarah Ann ST

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO Dehydration
(B) Intestenal Obstruction
DUE TO Inguinal hernia.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral contusion nothing to do with cause of death

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy; Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: 10-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-6-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county): Balto. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 322 N Schroeder St

VS 151

122a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78711

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450.0

Registered No. G78711

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Dixon

2. DATE OF DEATH: 10-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1807 Druid Hill Ave

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 1807 Druid Hill Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Widower | April 5, 1882 | 68 67 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Va. | U.S.A. |

13. FATHER'S NAME: Richard Dixon

14. MOTHER'S MAIDEN NAME: Sarah ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | | | Lillie Stewart | 1807 Druid Hill Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Myocarditis + Nephritis — ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 10-3-, 1949 to 10-4, 19 9, that I last saw the deceased alive on 10-4, 1949, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gilbert L. Barnes, M.D. | 722 N. Fulton Ave | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-7-1949 | Balto. National Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 1949 | Covington Williams, M.D. | Mrs Katie R. Williams | Schroeder St |

VS 150

131a

G78712

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

795.4

G78712

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) WADE R. CARTER

2. DATE OF DEATH October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-02
D. STREET ADDRESS (If rural, give location) 1526 Bruce Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | | March 5 | 1 | 7 | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10B. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Mervin Carter
14. MOTHER'S MAIDEN NAME Lucille Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Lucille Carter ADDRESS 1526 N. Bruce Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Undetermined - 795.4 | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.*

23A. SIGNATURE [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED October 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/8/49
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn
24D. LOCATION (City, town, or county) Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR OCT 6 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Geo. C. Nelson ADDRESS 1300 Pressman St.

VS 151

200 C

G78713 JE - 130816

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78713

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Grafton Dunaway

2. DATE OF DEATH: Oct. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-03
D STREET ADDRESS (If rural, give location): 1705 Mosher St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Div. | Mar. 23, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PORTER | ODD Jobs | Va. | |

13. FATHER'S NAME: Thomas Dunaway

14. MOTHER'S MAIDEN NAME: Adaline Conway

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | B. C. H. Records, 4940 Eastern Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lung abcess
DUE TO
(B) Bronchogenic Ca
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arterio-sclerotic cardio-vascular disease

INTERVAL BETWEEN ONSET AND DEATH:

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-7-49 | Rib biopsy | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 8-4 , 1949, *to* Oct. 4, , 1949, *that I last saw the deceased alive on* Oct. 4, 1949, *and that death occurred at* 7:15 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. E. Bogen, M. D. | 4940 Eastern Ave. | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/6/49 | Northumberland Co. | Northumberland Co. Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Washington Williams, M.D. | Geo. A. Kelson | 1303 Pennsylvania Ave |

VS 150

750

47c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 10-20-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G78714 — Registered No. G78714

1. NAME OF DECEASED (Type or Print): ~~WALKER~~ ~~WILLIS~~ WILLIS WALKER

2. DATE OF DEATH: October 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 55 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 917 Pierce Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Widowed | 7/12/1864 | 85 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed ?
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bessie Wilbard — ADDRESS: 1723 W. North Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 10-4-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10/8/49 | Mt. Calvary Cemetery | H. H. Co. Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 - 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Chas. F. Law. — ADDRESS: 802 Madison Ave

VS 151

420 P.6

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78715

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78715 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louise Thornton

2. DATE OF DEATH: 10/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 340 Camel St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 340 Camel St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Single | Sept. 18, 1908 | 41 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | U.S.A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Charles Thornton ADDRESS: 340 Camel St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: History indefinite

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 1 1941 *to* Oct 3, 1949, *that I last saw the deceased alive on* Oct 3, 1949, *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Garland Schnell M.D. | 1534 Druid Hill Ave | Oct 6 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/7/49 | Mt. Calvary Cemet. | Cedar Hill, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 6 1949 | Huntington Williams, M.D. | A. Halstead - 908 Druid Hill Ave |

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G78716

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

60

G78716

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Magill, Ethel C

2. DATE OF DEATH: Oct. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: LIFETIME (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 1900 N. Monroe

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Oct. 29 1888 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Dress Maker | Ladies Tailor | St. Mary's Co., Md. | |

13. FATHER'S NAME: Richard H. Magill

14. MOTHER'S MAIDEN NAME: Mary L. Rogard Mond.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 212-26-0852 | Sister (Mrs. Rates Kelly | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure
DUE TO
(B) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 4, 1949, *to* Oct 5, 1949, *that I last saw the deceased alive on* Oct 5, 1949 *and that death occurred at* 4:24 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mary E. Matthews M. D. | Mercy Hospital | Oct 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/7/49 | St. Joseph's Cem. | Morganza, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 6 1949 | Lexington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78717

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78717

1. NAME OF DECEASED (Type or Print): Edith Stevens Hoffman

2. DATE OF DEATH: October 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): Greenway Apts., Chas. & 34th St. Balto. Md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Wh. | Widowed | December 11, 1881 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10B. KIND OF BUSINESS OR INDUSTRY: (Physicians)
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: George Stevens
14. MOTHER'S MAIDEN NAME: Rebecca Tebbetts
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown. (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 220-07-8251
17. INFORMANT: Mrs. Ethel Hancock Hayden ADDRESS 133 Kentwood

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ASHD c Coronary Insufficiency
DUE TO
ANTECEDENT CAUSES
(B) Old Myocardial Infarctions
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) — (B) —

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 4, 1949, *to* Oct. 4, 1949, *that I last saw the deceased alive on* Oct. 4, 1949, *and that death occurred at* 11:00 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: Richard Beach M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 10/8/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108-28 North Ave

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93D City #1.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78718

BALTIMORE CITY HEALTH DEPARTMENT 331

# CERTIFICATE OF DEATH

G78718

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) SARAH CATHERINE LEE — Sarah Lee

2. DATE OF DEATH Oct. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore: Yrs. Lifetime Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01
D. STREET ADDRESS (If rural, give location) 1200 Valley street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | S. | Dec. 15, 1863 | 85 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Seamstress
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Lee
14. MOTHER'S MAIDEN NAME: Mary Joyce
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Celia Symonds ADDRESS 1200 Valley St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral Hemorrhage | 1 month |
| DUE TO | | |
| (B) | Arteio Sclerosis | 5 yrs |
| DUE TO | | |
| (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 4, 1949, to October 4, 1949, *that I last saw the deceased alive on* Oct 4, 1949, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Gill Hall M. D. | 1631 E North Ave | Oct 6 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-7-49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 1949 | Huntington Williams, M.D. | Chas. S. Conn & Son, Inc. | 110 West Mount Royal ave. |

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G78719 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 98.5 G78719 Registered No. 8719

1. NAME OF DECEASED (Type or Print): ORVAL E. ERICSON — N-869.2

2. DATE OF DEATH: October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen. Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-05
D. STREET ADDRESS (If rural, give location): 3109 Woodhome Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 10-1921 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bus Driver | Balto. Transit Co. | Nebraska | |

13. FATHER'S NAME: Edwin Ericson
14. MOTHER'S MAIDEN NAME: Martha Jacobson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs Hobart H Ericson - 3109 Woodhome |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Multiple stab wounds of chest and abdomen with exsanguination | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | public | Carey St. & Westwood Ave. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 5, 1949 Approx. 11:10 p.m. | WHILE AT WORK [X] NOT WHILE AT WORK [ ] | Sharp Instrument |

22. *I certify that I took charge of the remains described above, held an* Autopsy & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X] undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Russell S Fisher M.D. | | 10-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-10-49 | Baltimore Natural | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 6 1949 | Huntington Williams, M.D. | Leonard J Luck - 5305 Harford Rd. |

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Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Robert Fuller, JR N-933
2. DATE OF DEATH: Oct 4, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Jan 7, 1948 | 1 yr. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Fuller, Sr.
14. MOTHER'S MAIDEN NAME: Dallas May Kirig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: None.
17. INFORMANT: Father ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation following
DUE TO
(B) aspiration of vomitus during
DUE TO
(C) clonic convulsive seizure -
etiology undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 min.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6:40 A.M. 10/4/49 *to* 7:30 A.M. 10/4/49 *that I last saw the deceased alive on* 7:29 A.M. 10/4/49 *and that death occurred at* 7:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: R. A. Abraham M.D. M. D. | 23B. ADDRESS: University Hosp. | 23C. DATE SIGNED: 10/5/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: October 7/49 | 24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge | 24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Loring Byers ADDRESS: 5005 Ph. Ave.

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78721

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 77 v.0 G78721

Registered No.

1. NAME OF DECEASED (Type or Print) MARIE F. HERDA — N-918

2. DATE OF DEATH October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph's Hospital

c. Length of stay in Baltimore 12 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4351 Berger Avenue 26-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | June 12, 1900 | 49 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Heinrich Dohrmann

14. MOTHER'S MAIDEN NAME Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Mr. Arthur L. Herda ADDRESS 4351 Berger Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to

DUE TO

(B) Illuminating gas

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 4351 Berger Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 5, 1949 4.00 P.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Four burners on gas stove on but unlit

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Kopf M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED October 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10/8/49

24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 6 1949

REGISTRAR'S SIGNATURE Curtis for Williams, M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 678722 — Registered No. 18722

1. NAME OF DECEASED (Type or Print): CATHERINE PALMER — 2. DATE OF DEATH: 10/5/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — W. Balto Gen. Hos
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hospital
C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1439 Hanover St — 2-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | July 27, 1902 | 47 yrs | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Breeden
14. MOTHER'S MAIDEN NAME: Minnie Morgan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT'S ADDRESS: Mrs Myrtle V. Melvin 3710 Ed — married daughter

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia. (Renal insufficiency) | 4 months |
| DUE TO (B) | Malignant arteriolar nephro-sclerosis. | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 October, 1949, *to* 5 October, 1949 *that I last saw the deceased alive on* 5 Oct, 1949 *and that death occurred at* 8 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Tucker MD
23B. ADDRESS: West Baltimore Gen'l Hosp.
23C. DATE SIGNED: 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 10, 1949
24C. NAME OF CEMETERY OR CREMATORY: Loud on P L
24D. LOCATION (City, town or county): Balto City (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. Holland Ellenbogen & Son
ADDRESS: 440 S. Broadway

OCT 6 1950

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

121a

G78723 CERTIFICATE CORRECTED 10-10-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78723

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Florence V. Hynson

2. DATE OF DEATH: Oct 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1610 Patapsco St.
c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1610 Patapsco St. 23-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Feb 13, ~~1885~~ 1884 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Booth
14. MOTHER'S MAIDEN NAME: Phillips
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): no.
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs. Marie Hynson ADDRESS: 1610 Patapsco St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Congestive heart failure — | 3-4 weeks |
| DUE TO | (Pulmonary oedema) | |
| (B) | Hypertensive cardio-vas- | 2 |
| DUE TO | cular disease — | |
| (C) | Diabetes mellitus | 7/22/48 |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/22, 1948 *to* 10/5, 1949 *that I last saw the deceased alive on* 10/4, 1949 *and that death occurred at* 7a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Deiker M. D.
23B. ADDRESS: 1226 Hanover St.
23C. DATE SIGNED: 10/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 8/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet
24D. LOCATION (City, town, or county) (State): Balto City Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Howard Ellems & Son ADDRESS: 1400 Pleasant St

61

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78724 G78724

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Johannes Douren

2. DATE OF DEATH: October 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days: 1 day

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Long Island
D. STREET ADDRESS (If rural, give location): 63-41 Bourton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | | 1-28-92 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Business | Stamp. Col. | Armenia | |

13. FATHER'S NAME: Andrea Douren

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 year ±

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/5 1949 *to* 10/6 1949, *that I last saw the deceased alive on* 10/6 1949, *and that death occurred at* 9:05 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W. Wintrobe M. D. | JOHNS HOPKINS HOSPITAL | Oct 6 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Oct 8 49 | N.Y. City, N.Y. | New York |

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS: John D. Mitchell & Sons, 4900 Eastern Ave.

VS 150

Kensington Williams, M.D.

47D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 78725

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 78725

1. NAME OF DECEASED (Type or Print): Ralph Looney

2. DATE OF DEATH: OCT 6 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Arkansas
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lowell
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 12-26-43 | 5 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Arkansas | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Looney | Virginia Main |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema

DUE TO

(B) Congestive Heart Failure

DUE TO

Tetralogy of Fallot & extreme pulmonic stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10.6.49 | Tetralogy of Fallot - extreme pulmonic stenosis | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-4 1949 *to* 10-6 1949, *that I last saw the deceased alive on* 10-6 1949, *and that death occurred at* 8:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Don McCleskey M. D. | JOHNS HOPKINS HOSPITAL | 10.6.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10/9/49 | Springdale Cem | Springdale Ark |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams M.D. | Charles P. Towell & Son | Lowell Ark |

VS 150

157E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78726

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

795.4

Registered No. G78726

BIRTH NO. 49-15475

1. NAME OF DECEASED (Type or Print) GEORGE ROBINSON

2. DATE OF DEATH October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2930 Spellman Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | | July 28, 1949 | | 2 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Abram Robinson | Ruth Nicholson |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Abram Robinson | 2930 Spellman Rd |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Undetermined - 795.4 | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| (B) | | |
| DUE TO | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| A. J. McClafferty M.D. | | October 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 7/49 | Mt Calvary Cem | B C County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams, MD | Mrs. Robert A. Ellis & Son | 200 c 1129 N. Carolina St |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78727

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78727

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Adolph Johnson

2. DATE OF DEATH: Oct 4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 244 Augusta St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 244 Augusta St. S-02

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 25, 1905
9. AGE (In years last birthday): 44 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10B. KIND OF BUSINESS OR INDUSTRY: Meat Packing House
11. BIRTHPLACE (State or foreign country): Cherry Point St Mary County
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm Johnson
14. MOTHER'S MAIDEN NAME: Lorgeanna Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 218-10-1729

17. INFORMANT: Edna Johnson ADDRESS: 244 Augusta St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Coronary Thrombosis | 15 min s. |
| | DUE TO | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Angina Pectoris | 3 Months |
| | DUE TO | | |
| | (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-1, 19 49 *to* 10-4, 19 9, *that I last saw the deceased alive on* 10-1, 19 49, *and that death occurred at* 8:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Burwell M. D.
23B. ADDRESS: 121 Fairfield St
23C. DATE SIGNED: 10-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 7/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn M. Park
24D. LOCATION (City, town, or county): Woodlawn (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7- 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Mrs Robert G. Elliott + Daughter ADDRESS:

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

432 67

94a 1129 N. Carlton St

G78728

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

5 3

G78728

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Joseph B. Marks

2. DATE OF DEATH Oct. 6-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2322 Arbutus ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life 79 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lakeland 25-4
D. STREET ADDRESS (If rural, give location) 2322 Arbutus ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Mar. 24-1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired ATTENDANT | PARKING LOT | Baltimore Md | U.S. |

13. FATHER'S NAME Benjamin Marks

14. MOTHER'S MAIDEN NAME Jennie Marks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs. Annie E. Marks ADDRESS 2322 Arbutus ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

(B)

DUE TO

(C) Generalized Arteriosclerosis — 3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| NA | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NA | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 10, 1948 *to* Oct 6, 1949 *that I last saw the deceased alive on* Oct 5, 1949, *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Schuhbeck M. D. | 7301 Annapolis Rd | 10/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10-1949 | Glen Haven Mem | Glenburnie Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams, MD | Geo. E. Bayne Jr | 1512 Holland St |

VS 150

46 E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78729

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78729

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Ilgenfritz — 2. DATE OF DEATH: October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1932 Wilkens Ave 20-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 12/21/1878 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | Weaver Bros | Pennsylvania | U S A |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ✓ | — | ✓ | Edgar H. Wade | 1797 Park Ave Hale Thorpe 29 Mt |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Fractures
DUE TO
(B) Shock
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | public | Wilkens Avenue, 50' east of Payson St. |

| 21D. TIME (Month) (Day) (Year) OF INJURY | Hours | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| October 5, 1949 | Approx. 8 p m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Ped. struck by auto. 20/3 |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Emil H. Beyer M.D. | | 10-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/8/49 | Western Cem. | Edmondson + Longwood |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams, M.D. | John J. Bowen + Son | 901 Hollins St. |

VS 151 602 81 170C

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78730

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78730

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George F. Rost

2. DATE OF DEATH: Oct. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 812 W. Lombard St. 18-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | Unknown | 63 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Acme Bot Co. | Baltimore Md. | U S A |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ✓ | ✓ | — | Mrs Helen Treppe | 2808 Brighton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| Carl H. Pryer M.D. | | Oct. 4, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/8/49 | Mt Olivet Cem | 2930 Frederick Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 - 1949 | Huntington Williams, M.D. | John J. Cowan + Son | Hollins St. |

VS 151 988 12. 12B

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G78731

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78731

1. NAME OF DECEASED (Type or Print): DAVID A. SKUP

2. DATE OF DEATH: Oct. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4031 NORFOLK AVE.

c. Length of stay in Baltimore: 27 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4031 NORFOLK AVE 15-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | Dec. 27, 1907 | 41 | 9 | 9 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ACCOUNTANT | OIL CO. | NEW YORK | U.S.A. |

13. FATHER'S NAME: ISRAEL SKUP

14. MOTHER'S MAIDEN NAME: LEABETH HILLEL

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | W. Sp. | 4031 Norfolk Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ANGINA PECTORIS — INTERVAL BETWEEN ONSET AND DEATH: 30 MINUTES

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIO SCLEROSIS

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April 15, 1948 *to* Oct. 6th, 1949 *that I last saw the deceased alive on* Oct 6, 1949, *and that death occurred at* 1:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ward H. Rosenthal M. D. | 1907 Greenmount Ave | Oct. 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-7-49 | Hebrew Mt. Carmel | Dists Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

210 TV

94B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78732

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78732

1. NAME OF DECEASED (Type or Print): Viola P. Parker

2. DATE OF DEATH: Oct. 4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1038 N. Bentalou St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1038 N. Bentalou St. 16-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Jan. 29, 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | | Balto. Md. | |

13. FATHER'S NAME: William Hunt

14. MOTHER'S MAIDEN NAME: Jennie Anderson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT (Husband) ADDRESS |
|---|---|---|
| | | Mr. Charles E. Parker, 1038 N. Bentalou St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute Cardiac dilitation | 2 days |
| ANTECEDENT CAUSES | DUE TO (B) Cardio-vascular disease | ? |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 14, 1949 *to* Oct 3, 1949, *that I last saw the deceased alive on* Oct 3, 1949 *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Glassman M. D. | 2607 Maple Ave. | Oct 5 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 8/49 | Loudon Pk. 3801 Frederick Ave. | Balto. 29, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 - 1949 | Cunningham Williams, M.D. | Harry A. Dintaffe | 4101 Edmondson Ave. |

VS 150

931

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G787:33

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54

G787:33

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES MILLER

2. DATE OF DEATH: OCT. 5 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1837 RAMSEY ST

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE

c. Length of stay in Baltimore: Yrs. 19-04 Mos. Days

D. STREET ADDRESS (If rural, give location): 1837 RAMSEY ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | DEC. 11 1888 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CORKER + CHARGER

10B. KIND OF BUSINESS OR INDUSTRY: BETH. STEEL

11. BIRTHPLACE (State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: MILLER

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-09-5753

17. INFORMANT: WIFE ADDRESS: MRS MARY MILLER - 1837 RAMSEY ST

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of rectum — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION: Nov. 1 1948

19B. MAJOR FINDINGS OF OPERATION: Carcinoma of rectum

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/1 *,* 19 48 *, to* 10/6 *,* 19 49 *, that I last saw the deceased alive on* Oct 5 *,* 19 49 *, and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Miller M. D.

23B. ADDRESS: 2830 W Belvedere Ave

23C. DATE SIGNED: 10/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: OCT 8/1949

24C. NAME OF CEMETERY OR CREMATORY: MT OLIVET

24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Harry N Wilson ADDRESS: 410 Edmondson Ave

VS 150

3984

467

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B.C. 4921280

G787:34

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 225-49

G787:34

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NELSON, BABY Girl

2. DATE OF DEATH: 9-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U of Md Hosp

c. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto 27-09
D. STREET ADDRESS (If rural, give location): 4526 Marble Hall Rd Ft 12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | | Single | 9-21-49 | 0 | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baby | Baby | Md | US |

13. FATHER'S NAME: Alfred T. Nelson

14. MOTHER'S MAIDEN NAME: Rosa Lee

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Father | 4526 Marble Hall Rd Ft 12 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Premature
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Life

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | — |

22. *I hereby certify that I attended the deceased from* 29 Sep, 1949, to 30 Sep, 1949, *that I last saw the deceased alive on* 30 Sep, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Univ of Md Hosp | 9-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | OCT 4 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 1949 | Cuthbert for Williams, MD | Commissioner of Health | |

VS 150

159

G78735

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78735

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Florence Savage

2. DATE OF DEATH: Oct 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore Gen. Hospital
c. Length of stay in Baltimore: Life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 Ward
D. STREET ADDRESS (If rural, give location): 2430 Reisterstown Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov. 16, 1907 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | At Home | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Harry Hollander

14. MOTHER'S MAIDEN NAME: Anne B Hillowitz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Milton Savage | 2430 Reisterstown Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | (INTERVAL BETWEEN ONSET AND DEATH) |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia. | 25 days. |
| DUE TO (B) | Chronic Glomerular nephritis | 4-4 yrs. |
| DUE TO (C) | Chronic Hypertension and Eclampsia. | 4-5 yrs. 26 days. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | ~~Brain Abscess.~~ | 5 days. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | over | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 9/11, 1949, to 10/6, 1949, *that I last saw the deceased alive on* Oct 6, 1949, *and that death occurred at* 2:45 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. J. Levine Borzi M.D. | 3630 Spring Lake Ave. | 10/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 7, 1949 | Hebrew Friendship Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7- 1949 | Huntington Holbrook, M.D. | Sol Levinson & Bros | W North Ave 1126 |

VS 150

148a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 10/13/49

G78736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78736

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Silberg

2. DATE OF DEATH: Oct 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md. 9-01

D. STREET ADDRESS (If rural, give location): 502 Rose Hill Terrace

5. SEX: F. | 6. COLOR or RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.

8. DATE OF BIRTH: June 24 1865 | 9. AGE (In years last birthday): 84 | If under 1 Year: Months Days | If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Swearer

14. MOTHER'S MAIDEN NAME: Rachael J. Givens.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: A B. Leaf ADDRESS: 502 Rose Hill Terrace

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 45 min.

DUE TO

(B) Chronic Myocarditis — 5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1944 *to* Oct. 6, 1949 *that I last saw the deceased alive on* Oct. 6, 1949, *and that death occurred at* 10 30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: W T Cole M.D. | 23B. ADDRESS: 6014 York Road | 23C. DATE SIGNED: Oct. 6, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Oct 8 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem | 24D. LOCATION (City, town, or county) (State): Greenmount Cem Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7- 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD | 25. FUNERAL DIRECTOR: John C Moran | ADDRESS: 3000 E Baltimore St

VS 150

937

Physicians: please write the causes of death clearly and legibly. It is especially important.

G787:37

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

G787:37

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Berry

2. DATE OF DEATH: October 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1071 Myrtle Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1071 Myrtle Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1071 Myrtle Ave 17-07

5. SEX: Male
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 30, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY: Public
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Berry
14. MOTHER'S MAIDEN NAME: Oliva

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary Berry ADDRESS: 1071 Myrtle Ave.

## MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertension Cardio Vascular Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1/[illegible], to 10/4/49, that I last saw the deceased alive on 10/2, 1949, and that death occurred at 2:55 P.M., from the causes and on the date stated above.

23A. SIGNATURE: W. E. Carver M.D.
23B. ADDRESS: 223 Court St
23C. DATE SIGNED: 10/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-7-1949
24C. NAME OF CEMETERY OR CREMATORY: Balto. Rotund Ave
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Miss Katie R. Williams
ADDRESS: 322 N. Schroeder St.

VS 150

72071

925

G78738

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 43 Registered No. G78738

1. NAME OF DECEASED (Type or Print) Lucy M. Hunt.

2. DATE OF DEATH 10-5-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1043 Hartford Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1043 Hartford Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). A. STATE 1043 Hartford Ave B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 1043 Hartford Ave 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | C | Widow | Jan. 2, 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Durham, N. C. | U.S.A. |

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME Polley

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT Viola White ADDRESS 1043 Hartford Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C)

INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* 9/10/95 19__ *to* 10/5/95 19__, *that I last saw the deceased alive on* 10/4/95 19__, *and that death occurred at* 9:30 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D. 23B. ADDRESS 233 Cathedral 23C. DATE SIGNED 10/6/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-10-1949 | Mt. Auburn Cem. | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR OCT 7 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 322 N. Schroeder St.

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78739

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78739 Registered No.

1. NAME OF DECEASED (Type or Print): BABY JACKSON, James

2. DATE OF DEATH: October 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 302 S. Fremont Street 21-01

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 302 S. Fremont Street

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: April 15 1949
9. AGE (In years last birthday): If Under 1 Year: Months 5, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Minns
14. MOTHER'S MAIDEN NAME: Constance Jackson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Constance Jackson ADDRESS: 302 S. Fremont Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cholangioma of liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earle Voye M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: October 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-8-1949
24C. NAME OF CEMETERY OR CREMATORY: W.M. Auburn Cem.
24D. LOCATION (City, town, or county): Balto. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7 1949
REGISTRAR'S SIGNATURE: Lennington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Katie R. Williams
ADDRESS: 329 N. Schroeder St

VS 151

56E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78740

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 51 Registered No. G78740

1. NAME OF DECEASED (Type or Print): Thomas Gilbert

2. DATE OF DEATH: Oct. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1625 Shadyside Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: England
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
D. STREET ADDRESS (If rural, give location): 9-07

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 28, 1880

9. AGE (In years last birthday): 68 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner, retired

10B. KIND OF BUSINESS OR INDUSTRY: Coal Miner

11. BIRTHPLACE (State or foreign country): Preston, England

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr Junia Jackson — ADDRESS: 1625 Shadyside Road.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Secondary Anaemia

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 19 49 *to* Oct 5 19 49, *that I last saw the deceased alive on* Oct 5 19 49, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. J. Gardner M. D.

23B. ADDRESS: 3400 E Baltimore

23C. DATE SIGNED: 10/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/8/49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Parkville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

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46B

G78741

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78741

1. NAME OF DECEASED (Type or Print): Ida Bagley Weaver

2. DATE OF DEATH: 10/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3026 Darby st

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3026 Darby st 13-05

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ ~~DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 6/21/1899 | 50 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Va. | |

13. FATHER'S NAME: Jefferson Bagley

14. MOTHER'S MAIDEN NAME: Laura Voight

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Wesley D. Bagley | 2211 Monticello Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 Hrs.

DUE TO

(B) Arteriosclerotic C. V. Dis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* July 1, 1949, *to* Oct. 5, 1949 *that I last saw the deceased alive on* Oct. 5, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward L. Harriman M. D. | 4037 Falls Rd. | 10/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~OR CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/9/49 | St. Peters | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

937

G78742

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 33 Registered No. 4

G78742

1. NAME OF DECEASED (Type or Print): Rose D. Siachos
2. DATE OF DEATH: 10/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27 N. Carey St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 27 N. Carey St. 18-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | [illegible] 1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | Self | Poland | |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: [illegible]

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Katherine Goryan | 304 E. Lombard St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Senility c Senile dementia | 4 yrs |
| DUE TO (B) | Cerebral Arteriosclerosis | ? |
| DUE TO (C) | Generalized arteriosclerosis | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1, 1947, *to* Oct 5, 1949, *that I last saw the deceased alive on* Oct 2, 1949, *and that death occurred at* 2.58 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Braden, M. D. | 330 W. Fayette St | 10/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Balto. | 10-8-49 | [illegible] | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 - 1949 | Huntington Williams, M.D. | Wm. J. Inc. | 27 St. Paul St. |

VS 150

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78743

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903,0

G78743

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Lillian Backus

2. DATE OF DEATH 10-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1917 McHenry St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widowed | 1881 | 68 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | N.Y. | U.S.A. |

13. FATHER'S NAME Henry Gregg

14. MOTHER'S MAIDEN NAME Martha Hyslip

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT |
|---|---|---|---|
| ND | | | Beatrice Backus, Daughter, 1917 McHenry St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema
DUE TO H.
(B) Left Ventricular Fail.
DUE TO
(C) Fracture Rt Femur

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R. H. Fisher M. D.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (Give exact location) |
|---|---|---|
| Home Accident | Home | 1917 McHenry St. 20/3 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 9-30-49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Pt fell while dizzy to floor |

22. I hereby certify that I attended the deceased from 10-1, 1949 to 10-6, 1949 that I last saw the deceased alive on 10-6, 1949, and that death occurred at 6:20 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edwin M. Hubbard M. D. | University Hosp. | 10-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Interment | 10/8/49 | Lorraine Mausoleum | Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 | Curington Williams, M.D. | Wm Cook Inc. | 127 St. Paul St. |

VS 150

186a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78744 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78744 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Oscar Calvin Bull

2. DATE OF DEATH: October 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 836 Wellington Street

c. Length of stay in Baltimore: 69 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 836 Wellington Street 13-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | August 3, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist | Burt Machine Co. | Maryland | U S A |

13. FATHER'S NAME: Silas Nicholas Bull

14. MOTHER'S MAIDEN NAME: Frances McCauley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 212-01-4967 | Mrs. Ruth Craig | 838 Wellington Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Cardiac disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Jan 1977, *to* Oct 6, 1949 *that I last saw the deceased alive on* Oct 4, 1949 *and that death occurred at* 10 30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 8429 Chesterfield Ave | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10, 1949 | Moreland Memorial Park | Baltimore Co., Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams, M.D. | Burgee Funeral Home | 3631 Falls Road |

VS 150 3-46 60

93D

G78745 Almeda Mc Intosh ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78745

BIRTH NO. 51 Registered No. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) ALMEDA McINTOSH

2. DATE OF DEATH 10/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT
C. Length of stay in Baltimore 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-04
D. STREET ADDRESS (If rural, give location) 2134 NORTON AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Fe | N | | 7/2/07 | 42 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN
10B. KIND OF BUSINESS OR INDUSTRY Beauty Shop
11. BIRTHPLACE (State or foreign country) SC.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME SAM McINTOSH
14. MOTHER'S MAIDEN NAME SUNEAN [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT DECEASED ADDRESS [illegible]

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA OF STOMACH
DUE TO
(B) WITH ASCITES AND
DUE TO
(C) CARCINOMATOSIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) UNKNOWN
(B)
(C)

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/29, 19[illegible], *to* [illegible], 19[illegible], *that I last saw the deceased alive on* 10/3, 19[illegible], *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.
23B. ADDRESS [illegible]
23C. DATE SIGNED 10/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/9/49
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn
24D. LOCATION (City, town, or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR OCT 7 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Eugene H. Mayo
ADDRESS 825 Harlem ave

VS 150
700 89
46

G78746

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78746

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS HARVEY

2. DATE OF DEATH: Oct. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Beck's Hospital, St. Paul & 23rd Sts.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Wyman Park Apts. 12-07

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Nov. 29, 1884
9. AGE (In years last birthday): 64 yrs. If under 1 year: Months, Days. If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief Hull Inspector
10B. KIND OF BUSINESS OR INDUSTRY: U. S. Maritime Comm
11. BIRTHPLACE (State or foreign country): Glasgow, Scotland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: - Harvey
14. MOTHER'S MAIDEN NAME: Mary -
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Loretta T. Harvey ADDRESS: Wyman Park Apts.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* Oct 4th, 1949 *to* Oct 5, 1949, *that I last saw the deceased alive on* Oct 5, 1949, *and that death occurred at* 11:10P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathaniel M Beck M. D.
23B ADDRESS: 100 E. 23rd St. Balto. Md.
23C DATE SIGNED: Oct 6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B DATE: 10/8/49
24C NAME OF CEMETERY OR CREMATORY: Greenmount Crematory
24D LOCATION (City, town, or county) (State): Balto., Md.

[redacted] RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

31F 97

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78747

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78747

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): JOHN HENRY HOLDEFER

2. DATE OF DEATH: Oct. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 944 N. Collington Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 944 N. Collington Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | June 25, 1863 | 86 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Holdefer

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: Mr. Frederick Holdefer,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Dilatation of Heart | 10 days |
| DUE TO | | |
| (B) | Myocardial Degeneration | |
| DUE TO | | |
| (C) | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Feb. 20, 19[illegible] *to* Oct. 6, 1949, *that I last saw the deceased alive on* Oct. 5, 1949, *and that death occurred at* 7.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Vincent V. Cooke M.D.

23B. ADDRESS: 2623 E. Monument St.

23C. DATE SIGNED: 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/10/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.

24D. LOCATION (City, town, or county) (State): North Ave. & Rose St. Balto.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

927

G7874 8 Joseph Staab G7874 8

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Staab

2. DATE OF DEATH: Oct. 6 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 532 N. Streeper St. (If not in hospital or institution, give street address or location)

B. FULL NAME OF HOSPITAL OR INSTITUTION: Home - 532 N. Streeper St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 532 N. Streeper St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | 1867 Feb 5. | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Furniture refinisher | Furniture | Maryland | U.S.A. |

13. FATHER'S NAME: Philip Staab

14. MOTHER'S MAIDEN NAME: Mary Schlee

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | about 1898 | None | Joseph H. Staab | 822 N. Calhoun St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Occlusion | 6 hours |
| DUE TO (B) | Generalized Arteriosclerosis | Unknown |
| DUE TO (C) | None | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | None | None |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | WHILE AT WORK ☐ None WHILE AT WORK ☐ | None |

22. *I hereby certify that I attended the deceased from* Oct. 2 49, 19 49 *to* Oct. 6, 19 49, *that I last saw the deceased alive on* Oct. 5, 19 49, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Carl Myers, M. D. | 533 E. Cold Spring Lane | Oct. 6 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/8/49 | Holy Redeemer Cem. | 4430 Belair Rd. Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 7- [illegible] | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-5-5 E. Madison St. |

VS 150 45785

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

G78749

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78749 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) HERMAN SAVAGE

2. DATE OF DEATH October 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 651 George Street 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | single | 6-10-46 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Restaurant | N. C. | |

13. FATHER'S NAME Wiley Savage

14. MOTHER'S MAIDEN NAME Lana Hill

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Felix savage 4143 Sherman ave CINN, OHIO |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Advanced pulmonary tuberculosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Boyle M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED October 4, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-7-1949 | Mt. Olivet Cemetery | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7 1949 | Huntington Williams M.D. | William A. Jackson & Sons Inc. | 916 13D |

HD 151

G78750

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. G78750 Registered No. 6.1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Henry G. Hahn
2. DATE OF DEATH: 10/5/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1616 N. Bradford St.
C. Length of stay in Baltimore: Yrs. Life Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto - Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md. 8-07
D. STREET ADDRESS (If rural, give location): 1616 N. Bradford St.
5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7/13/70
9. AGE (In years last birthday): 79 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Balto -
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: Anna Miller - 1616 N. Bradford St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Carcinoma of Liver & General metasteses — 1year
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1949 *to* Oct. 5, 1949 *that I last saw the deceased alive on* Oct. 4, 1949, *and that death occurred at* 11:20 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert E. Singewald
23B. ADDRESS: 1613 E. North Ave.
23C. DATE SIGNED: 10-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/8/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore - Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Lilly & Zeller - 403 S. Wolfe St.

OCT 7 1949

46F

G78751

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78751

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Theodore McCauley

2. DATE OF DEATH: Oct 6 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 724 W. Lexington St
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 4-6 W
D. STREET ADDRESS (If rural, give location): 724 W. Lexington St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | Under 1 Year: Months / Days | Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | Dec 17-1890 | 59 5-7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Helper | Bakery | Balto Md. | |

13. FATHER'S NAME: Emanuel McCauley

14. MOTHER'S MAIDEN NAME: Anna Lindwig

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Isaac Steinfelt | 724 W Lexington St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Cerebro-Vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 30, 1949 *to* Oct 6, 1949, *that I last saw the deceased alive on* Oct 4, 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Steinman M. D. | 768 7 Mayfield Ave | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Oct 8-1949 | Woodlawn Cem | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7- 1949 | Lillian Williams, M.D. | Isaac Steinfelt & Son | 724 W. Lexington St |

VS 150

937

G78752

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78752

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Bernard A. Landau

2. DATE OF DEATH: Oct. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marine Hospital (DCA)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 344 E. Belvedere Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | Nov. 22-1890 | 58 | | | | |

| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10a. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Paint Salesman | Bruening Bro | New York City | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Bernard Landau | Katherine |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Irene G. Landau | Belvedere 344 E |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Tuberculosis with cavitation | 2 yrs. |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D. | | Oct. 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/8/49 | Moreland Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 7- 1949 | Registrar for Baltimore, Md | Leonard J. Leuck | 5305 Harford Rd |

VS 151

278 15

136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78753

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78753

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Collison

2. DATE OF DEATH: 10/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 9-07
D. STREET ADDRESS (If rural, give location): 1556 Abbottson St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | Nov. 13, 1890 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Contractor | General Contracting | Baltimore, Md. | USA |

13. FATHER'S NAME: Peter Collison

14. MOTHER'S MAIDEN NAME: Mary Shirdy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: none

17. INFORMANT: Bernard Heilker-1556 Abbottson St. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocardial Degeneration
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. Shulwinski M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: 10/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial | 24B. DATE: 10/8/49 | 24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem. | 24D. LOCATION (City, town, or county) Baltimore, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. (ADDRESS) BALTIMORE - 13, MARYLAND

152 V9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G78754

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

193 Registered No. G78754

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH K. LEITCH

2. DATE OF DEATH: Oct. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1536 Kingsway Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1536 Kingwsay Rd., Northwood 27-09

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 17, 1886
9. AGE (In years last birthday): 63 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Wittmer
14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mr. John H. Leitch ADDRESS: 1536 Kingsway Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 16-May-1949
19B. MAJOR FINDINGS OF OPERATION: Brain Tumor (Glioma)
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-Feb, 1949 *to* 6-Oct, 1949 *that I last saw the deceased alive on* 6-Oct, 1949 *and that death occurred at* 11.20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chas W. Edmunds M. D.
23B. ADDRESS: 2746 The Alameda
23C. DATE SIGNED: 7-Oct-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/10/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 7
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

54a

PLEASE WRITE PLAI... WITH UNFA... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78755

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78755

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Albert Stevenson

2. DATE OF DEATH: Oct. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 714 W. Redwood St. 4-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | D | 6-10-81 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.Y.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: St. Vincent De Paul

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteri. Sclerotic Cardiac,
DUE TO
(B) Vascular Disease
DUE TO
(C)

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED: Oct. 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): German Hill Rd

DATE RECEIVED BY REGISTRAR: OCT 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J.J. Fahey & Sons
ADDRESS: 1318 Light St

VS 151

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as nearly as age is especially important. Physicians: please write the causes of death clearly and legibly.

G78756 BALTIMORE CITY HEALTH DEPARTMENT G78756

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) CHARLOTTE MILLER
2. DATE OF DEATH 10/7/49 7:10 A.M.
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SYDENHAM HOSPITAL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 16 16-06
C. Length of stay in Baltimore: ALL HER LIFE (Yrs. Mos. Days)
D. STREET ADDRESS (If rural, give location) 607 N. FRANKLINTOWN ROAD.
5. SEX F
6. COLOR or RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH 1/13/1928
9. AGE (In years last birthday) 21 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) BALT., MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ROBT. H. KELLER
14. MOTHER'S MAIDEN NAME SARA MILLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO 213-26-6471
17. INFORMANT HUSBAND ADDRESS 607 N. FRANKLINTOWN RD

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ? CARDIO RESPIRATORY FAILURE
DUE TO
(B) ACUTE ANT. POLIOMYELITIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 10/6, 1949, to 10/7, 1949, that I last saw the deceased alive on 10/6, 1949, and that death occurred at 7:10 A. m., from the causes and on the date stated above.

23A. SIGNATURE Milton Pyastowsky M. D.
23B. ADDRESS Sydenham Hospital
23C. DATE SIGNED 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 10/49
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR OCT 8th 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Chas P. Towell
ADDRESS 2427 Edmondson Ave

36

G78757 BALTIMORE CITY HEALTH DEPARTMENT G78757

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Harry Wheatley

2. DATE OF DEATH: Oct 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5712 O'Donald St. 26 0 5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | D | Feb. 20, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Cemetery | Baltimore | |

13. FATHER'S NAME: James W.

14. MOTHER'S MAIDEN NAME: not known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Eva Rafferty 1144 Steelton Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. McClafferty M.D | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: Oct. 6, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/10/49 | Oak Lawn | 7225 Eastern Ave. |

DATE RECEIVED BY LOCAL REGISTRAR: [illegible] 8, 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D | 25. FUNERAL DIRECTOR ADDRESS: Clarence F. Hoffmann 1639 Broadway.

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G78758

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4/63

G78758

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY E. FOSS

2. DATE OF DEATH 10-6-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1509 Patapsco St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.
c. Length of stay in Baltimore 57 Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. 23-02
D. STREET ADDRESS (If rural, give location) 1509 Patapsco St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Fe. | W. | [redacted] W | 2/28/1891 | 58. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor | Home | Md. | U.S.A. |

13. FATHER'S NAME August Martin

14. MOTHER'S MAIDEN NAME Catherine O'Hara

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 215-03-4911 | Mrs. Dolores Price | (SAME) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism

DUE TO

(B) Thrombophlebitis, right leg.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-5, 1949, to 10-6, 1949 *that I last saw the deceased alive on* 10-6, 1949 *and that death occurred at* 9:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ben B. Lamp M.D. | FRANKLIN SQ. HOSP. | 10/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial - | Oct. 10, 1949 | Western Cemetery | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 6 [redacted]

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: P. Bowen Evans - 4003 Chesterfield. ADDRESS: Baltimore 30, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Be correct age is especially important.

VS 150

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078759

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

078759

BIRTH NO

Registered No.

1. NAME OF DECEASED (Type or Print): Mary F. Falter

2. DATE OF DEATH: Oct. 7, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 1829 W. Lexington

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1829 W. Lexington

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1829 W. Lexington St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Nov. 7, 1910 | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Harpers Ferry, W. Va. | U.S. |

13. FATHER'S NAME: William H. Bragg

14. MOTHER'S MAIDEN NAME: Wesha Short

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 235-26-1713 | Joseph F. Falter Jr. | 1829 W. Lexington St |

## MEDICAL CERTIFICATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast

DUE TO with osseous and

(B) visceral metastases.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8-10 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1941 | Carcinoma of Breast | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | — |

22. *I hereby certify that I attended the deceased from* Sept. 1947 *to* Aug. 1949, *that I last saw the deceased alive on* Aug. 1949, *and that death occurred at* 2 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward F. Lawrence M.D. | 1020 St. Paul St. | 10/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Oct 9, 1949 | Family Burial Under | Hill Top, W. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 1949 | Huntington Williams, M.D. | Howard W. Hubbard | 2503 Edmondson Ave. |

VS 150

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Dr. E.J.Alessi

6217 Harford 8760

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 1 678760 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Nora A. Cooney

2. DATE OF DEATH: Oct. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3010 Christopher Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3010 Christopher Avenue

27-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | May 14, 1872 | 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Upper Crossroads, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Patrick Kennedy

14. MOTHER'S MAIDEN NAME: Anna Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr. C.E.Batchelor, ADDRESS: 3010 Christopher

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis — ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* August 25, 1944, *to* October 7, 1949, *that I last saw the deceased alive* October 7, 1949, *and that death occurred at* 8.30A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. E. Alessi M. D. | 6217 Harford Rd | 10/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-10-49 | St. John's | Long Green, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 8- 1949 | Huntington Williams, M.D. | Leonard J. Ruck, 5305 Harford Road. |

VS 150

92D

Dr. Jandorf G78761 G78761
6077 Harford.

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 59

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): **Elizabeth Roeder**

2. DATE OF DEATH: **Oct. 7, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **2907 Westfield Avenue**
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore**
D. STREET ADDRESS (If rural, give location): **2907 Westfield Avenue** 27-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) |
|---|---|---|
| **female** | **white** | **widowed** |

| 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|
| **Apr. 16, 1873** | **76** | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **at home**
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): **Germany**
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: **? Scheel**
14. MOTHER'S MAIDEN NAME: **Eve Krak**
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: **Miss Elsie Roeder, 2907 Westfield** ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Carcinoma (right upper quadrant) abdomen.** DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: **Hypertensive CVD**

INTERVAL BETWEEN ONSET AND DEATH: (A) **1 year** (B) (C) **20 yrs**

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **March**, 1949, *to* **Oct. 6**, 1949, *that I last saw the deceased alive on* **Oct 6**, 1949, *and that death occurred at* **10** A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: **Ronald Jandorf** M. D.
23B. ADDRESS: **6077 Harford Rd 14**
23C. DATE SIGNED: **10-6-49**

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **10-10-49** | **Lorraine Park** | **Baltimore, Maryland** |

DATE RECEIVED BY LOCAL REGISTRAR: **OCT 8 1949**
REGISTRAR'S SIGNATURE: **Huntington Williams, MD**
25. FUNERAL DIRECTOR ADDRESS: **Leonard J. Ruck, 5305 Harford Road.**

VS 150

55E

Dr. Harding G78762 ✓ G78762

3805 Belair

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

1. NAME OF DECEASED (Type or Print): **Alois Kadrabek**

2. DATE OF DEATH: **Oct. 7, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **4104 Montana Avenue**
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: **Maryland**
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore**
D. STREET ADDRESS (If rural, give location): **4104 Montana Avenue** 7/-34

5. SEX: **male**
6. COLOR OR RACE: **white**
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): **married**
8. DATE OF BIRTH: **July 28, 1871**
9. AGE (Years last b[irthday]): **78** | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or Foreign country): **Austria**
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: **Frank Kadrabek**
14. MOTHER'S MAIDEN NAME: **?**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: **Mrs. Marie Kadrabek, 4104 Montana Ave**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Ch. Myocarditis**
DUE TO
(B) **Ch. Hypertension**
DUE TO
(C) **Arteriosclerosis**

ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: **2 years**

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **Aug** , 19**49**, *to* **Oct 7** , 19**49**, *that I last saw the deceased alive on* **Oct 5** , 19**49**, *and that death occurred at* **8a** *m., from the causes and on the date stated above.*

23A. SIGNATURE: **J Harding** M. D.
23B. ADDRESS: **3805 Belair Rd**
23C. DATE SIGNED: **Oct 7/49**

24A. BURIAL, CREMATION, REMOVAL (Specify): **Burial**
24B. DATE: **10-10-49**
24C. NAME OF CEMETERY OR CREMATORY: **Holy Redeemer**
24D. LOCATION (City, town, or county) (State): **Baltimore, Md.**

DATE RECEIVED BY LOCAL REGISTRAR: **OCT 8 1949**
REGISTRAR'S SIGNATURE: **Huntington Hollins, M.D.**
25. FUNERAL DIRECTOR ADDRESS: **Leonard J. Ruck, 5305 Harford Road.**

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

92

G78763

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 G78763 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Caroline McCabe Morgan

2. DATE OF DEATH: Oct-7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 305 Woodlawn Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home
c. Length of stay in Baltimore: 40 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 305 Woodlawn Road 27-14

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct-30-1874
9. AGE (In years last birthday): 74 years (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chicago, Ill
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Robert Robinson McCabe
14. MOTHER'S MAIDEN NAME: Clara E. Emmons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): None
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mr. Philip S. Morgan, 305 Woodlawn Road (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
ANTECEDENT CAUSES
(B) Arterio Sclerosis —
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Myocardial Insufficiency

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. 0

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: 0
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 0
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1st 1946, *to* Oct 7th, 1949, *that I last saw the deceased alive on* Oct 7, 1949, *and that death occurred at* 10:24 m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 200 N. Calvert St
23C. DATE SIGNED: Oct 7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: October-10-49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 1949 (OCT 8 1949 VS 150) OCT 8T 1949
REGISTRAR'S SIGNATURE: [signature] Remington, Millicent, Md
25. FUNERAL DIRECTOR (ADDRESS): Stewart & Mowen Co., 108 W. North Avenue.

822 City #1.

G78764 G78764

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E890.0

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Ima Virginia Hoffman Hoffman N-965 | 2. DATE OF DEATH: Oct. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Years, Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2324 N. Charles St. 12-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | March 10, 1895 | ? 54 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Nurse (RN) | Hospital | Hagerstown, Maryland | |

13. FATHER'S NAME: John Henry Hoffman
14. MOTHER'S MAIDEN NAME: Anne Amelia Schweitzer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | None | NONE | Miss Helen Hoffman | 4536 49th St. Wash. N.W. DC. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon - monoxide poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2324 N. Charles St. 12/6
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 28, 1949 7 Pm.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Escaping coal gas from furnace

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 7, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10, 1949 | | Funkstown, Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8- 1949
REGISTRAR'S SIGNATURE: Thomas Lee Williams M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Company
ADDRESS: 108 W. North Ave. Balto. 1, Md.

V36 178c

BIRTH NO. G78765

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 17

Registered No. G78765

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): ALICE HOOTEN

2. DATE OF DEATH: 5 Oct 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. Carey st
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 543 Bal
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) B [illegible] 22-02
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Colored. | Col | | | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife. | | | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the breast
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 24 Aug, 1949, *to* 5 Oct, 1949, *that I last saw the deceased alive on* 5 Oct, 1949, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil W. Henning Jr M. D. | 4580 Edmondson Ave | 7 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 7 49 | [illegible] | [illegible] |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 1949 | [illegible] M.D. | [illegible] | [illegible] |

VS 150

50

BIRTH NO. G28766

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G28766

1. NAME OF DECEASED (Type or Print): AMY FRANCES LINTON

2. DATE OF DEATH: Oct. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 Bolton St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1604 Bolton St. 14 01

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 8, 1884
9. AGE (In years last birthday): 65 yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant
10B. KIND OF BUSINESS OR INDUSTRY: Children's School for Cerebral Palsied
11. BIRTHPLACE (State or foreign country): Malden, W. Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Linton
14. MOTHER'S MAIDEN NAME: Lucy ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): np
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 218-18-0790
17. INFORMANT: Miss Lola Shifler - 1604 Bolton St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CORONARY THROMBOSIS | 18 hours |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Moderate hypertension | ? |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 5, 1949, *to* Oct. 6, 1949, *that I last saw the deceased alive on* Oct. 5, 1949, *and that death occurred at* 5:05A m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Ellsworth Cook M. D.
23B. ADDRESS: 2431 Maryland Ave.
23C. DATE SIGNED: 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/8/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8- 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

OCT 8- 1949

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G78767 ✓

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | 157 Registered No. G78767

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): LULA M. COLEMAN

2. DATE OF DEATH: October 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4300 Ashland Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4300 Ashland Ave. 2-6-44

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | April 29, 1871 | 78 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Shrewsbury, Pa.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William H. Heindle
14. MOTHER'S MAIDEN NAME: Leah Schaefer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. J. Thomas Coleman, Jr. ADDRESS: 4300 Ashland Av

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
(A) Carcinoma of pancreas. — INTERVAL BETWEEN ONSET AND DEATH: 18 mos.
DUE TO: CARCINOMA OF PANCREAS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION: Apr. 12 - 1948
19B. MAJOR FINDINGS OF OPERATION: Exploratory - Carcinoma of pancreas
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr. 12, 1948, *to* Oct. 6, 1949, *that I last saw the deceased alive on* Oct. 6, 1949, *and that death occurred at* 11.30a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm J Schmidt M. D.
23B. ADDRESS: 701 N. Howard Ave.
23C. DATE SIGNED: 10/7/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/10/49 | Evangelical Lutheran Cem. | Shrewsbury, Pa. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

OCT 8 1949

469

G78708

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G78708 Registered No.

1. NAME OF DECEASED (Type or Print) Clara Louise Ruark

2. DATE OF DEATH Oct 7. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3534. 7th St. Brooklyn
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY Hoopersville Md. Dorchester Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore 3 weeks (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 3534 7th. St. Brooklyn 25-4

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Mar. 18. 1872
9. AGE (In years last birthday) 77 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dorchester Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Perry Tyler
14. MOTHER'S MAIDEN NAME Mary E. V.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Leland D. Mills ADDRESS 3534 7th. St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-Sclerotic Cardio-Vascular

DUE TO Renal Disease

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1 1949 to Oct. 7 1949, *that I last saw the deceased alive on* Oct 9 1949, *and that death occurred at* 8. P m., *from the causes and on the date stated above.*

23A. SIGNATURE Chas Lubin M. D.
23B. ADDRESS 320 Watkins Ave
23C. DATE SIGNED 10/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 9/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Cambridge Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 7-1949
REGISTRAR'S SIGNATURE Registrar for Baltimore, Md
25. FUNERAL DIRECTOR John O. Mitchell Sons ADDRESS 1900 Eutaw Place

OCT 8-1949

1310

G78769

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G78769

Registered No. G 78769

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Col. Samuel W. Filbert

2. DATE OF DEATH: Oct. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2200 Mt. Royal Terrace

C. Length of stay in Baltimore: Yrs. – Mos. – Days –

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2200 Mt. Royal Terrace

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Aug. 9, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Officer | U.S. Army | Pennsylvania | U.S. |

13. FATHER'S NAME: Isaac Filbert

14. MOTHER'S MAIDEN NAME: Mary Hesst 13-01

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | – | – | Mrs. Katie F. Eiker | 4513 6th St., N.W. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — Interval between onset and death: 4 days

DUE TO

(B) Hypertensive Cardiovascular Disease — Interval between onset and death: 3 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6-3-47, *to* 10-6-49, *that I last saw the deceased alive on* 10-5-49, *and that death occurred at* 2:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clifford F. Hudson M.D. | Fork, Md. | 10/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-8-49 | Lorraine | Woodlawn, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 10-8-49 | Huntington Williams, MD | John O. Mitchell & Sons, Inc. 1900 Eutaw Place |

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Please write plainly, WITH UNFADING INK. Every item of information should be carefully given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78770 ✓ 3 2 G78770

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen M.Courtney

2. DATE OF DEATH: 10-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2705 Hamilton Avenue
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2705 Hamilton Avenue 27-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | 10-10-1856 | 92 93 | II | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: John Gardner

14. MOTHER'S MAIDEN NAME: Helen ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Mrs.Agnes M.Ryan- | 2705 Hamilton Ave. |

## MEDICAL CERTIFICATION

19. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Arteriosclerosis

DUE TO

(B) Cerebral Thromboses.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept, 1947 *to* Oct, 1949 *that I last saw the deceased alive on* Oct 1, 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas J. Brennan M. D. | 5217 Harford Road (14) | 10-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-10-49 | New Cathedral Cemetery | Edmondson Ave.Balto:Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 8 1949 | | George J.Ruth,Inc. | 1735 Harford Ave. |

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OCT 8 1949

836

G78771

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 442

BIRTH NO. G78771 Registered No.

1. NAME OF DECEASED (Type or Print): Herman M. Lehman

2. DATE OF DEATH: October 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3806 Elm Avenue
c. Length of stay in Baltimore: 46 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3806 Elm Avenue 13-07

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: May 1, 1869
9. AGE (In years last birthday): 80 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Job work
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: U S A
13. FATHER'S NAME: Michael Lehman
14. MOTHER'S MAIDEN NAME: Anna Melda
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ---
17. INFORMANT: Mrs. Thomas W. Shortess ADDRESS: 3806 Elm Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiovascular renal disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1945 *to* Oct 7, 1949 *that I last saw the deceased alive on* 10/7, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm M. McFaul Jr. M. D.
23B. ADDRESS: 840 W. 36th St.
23C. DATE SIGNED: 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 10, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

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correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78772 ✓ G78772

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

16 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leroy Eyler

2. DATE OF DEATH 10-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 57 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 221 E. Lafayette Ave. 12-05

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid | 8. DATE OF BIRTH Feb. 12, 1888 | 9. AGE (In years last birthday) 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Molder

10B. KIND OF BUSINESS OR INDUSTRY Carbs Home Improvement

11. BIRTHPLACE (State or foreign country) Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Henry Eyler

14. MOTHER'S MAIDEN NAME Katherine Ridenover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-05-3252

17. INFORMANT B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchogenic Carcinoma

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION Sept. 16, 1949

19B. MAJOR FINDINGS OF OPERATION Repair of Rt. indirect Inguinal Hernia

20. AUTOPSY? YES Yes NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-6, 1949, *to* Oct. 6, 19 49 *that I last saw the deceased alive on* Oct. 6, 19 49, *and that death occurred at* 10.45 PM *from the causes and on the date stated above.*

23A. SIGNATURE R. S. Rogan M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED Oct. 7, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Inter

24B. DATE 10/10/49

24C. NAME OF CEMETERY OR CREMATORY Druid Ridge

24D. LOCATION (City, town, or county) (State) Catonsville Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 8 - 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Gilbert Bros. ADDRESS 122 St. Paul St.

OCT 7 1949

OCT 8 - 1949

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Please write plainly in ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78773

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 G78773

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) LILLIAN MABEL WALKER

2. DATE OF DEATH 10/7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 401 N. Pulaski St #23

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 7/29/92

9. AGE (In years last birthday) 57

If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Harry

14. MOTHER'S MAIDEN NAME Martha Nebb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Robert J. Walker ADDRESS 8538 Chesterwood Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 wks.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/7 1949 *to* 10/7 1949, *that I last saw the deceased alive on* 10/6 1949, *and that death occurred at* 7:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Blazek M.D.

23B. ADDRESS Maryland General

23C. DATE SIGNED 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10/10/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 8 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Wilhom & Dne ADDRESS 1218 E Fay St

VS 150

Written for Millimeter, Md

94a

"Every item of information should be carefully supplied, with UNFAILING ACCURACY, as this record is a permanent legal document.

G78774

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G78774

1. NAME OF DECEASED (Type or Print): John W. Earhardt (or) Erhart

2. DATE OF DEATH: Oct 6 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 255 S. Durham St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 255 S. Durham St 2-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Sept 19 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Inspector | Con. Can Co. | Balto. | U.S.A. |

13. FATHER'S NAME: Benjiman Earhardt

14. MOTHER'S MAIDEN NAME: Mamie Keysair

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 215-01-6708 | William A. Earhardt | 255 S. Durham St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary oedema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac failure

DUE TO

(C) Cirrhosis of Liver

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Jaundice - 5

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | | — |

22. I hereby certify that I attended the deceased from June, 1949, to Oct 6, 1949, that I last saw the deceased alive on Oct 6, 1949, and that death occurred at 10:55 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin J. Zamorski, M.D. | 2711 Eastern Ave. | Oct 7 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 10-49 | Oak Lawn Cem. | Eastern Ave Rd Balto Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 1949 | Huntington Williams, M.D. | Diggs Bro. | 1800 E. Lombard St. |

OCT 8 1950

496 3V

124R

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78775 ✓ G78775

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosa Cosima Di Paula
2. DATE OF DEATH: Oct 7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1805 E. 33rd St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 72 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 1805 E. 33rd St 7-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F. | W. | Married | Sept. 27 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | House work | Italy | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Giambaris Dantoni | Catherina Dantoni |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Salvatore Di Paula | 1805 E 33rd St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Fragmentation | 3 yrs |
| DUE TO (B) | Hypertension | + 6 yrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1-1-49, 19__, *to* 10/7/49, 19__, *that I last saw the deceased alive on* 10/6/49, 19__, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. H. Herrman M.D. | 1710 E 33rd St | 10/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10-49 | Balto. Cem. | E. Northern Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 8 50 1949 | Cuntz for Nottingham Md | Riggel Bros. | 1800 E Lombard St. |

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78776

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G78776

1. NAME OF DECEASED (Type or Print): Josephine Griner

2. DATE OF DEATH: Oct. 6. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1911 E. Chase St.

C. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1911 E. Chase St.

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Oct. 2. 1907
9. AGE (In years last birthday): 42 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Augusta Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Annie Chant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: John H. Griner ADDRESS: Glenburney Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: sev. hrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) arterio-sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: V.V.K.
DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY? (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-7 1949 to 10-6 1949 that I last saw the deceased alive on 9. 20 1949 and that death occurred at 4 30 p m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] 1500 EAST MADISON ST.
23B. [illegible] M. D.
23C. DATE SIGNED: 10-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 9.1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 - 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Elroy O. wilson ADDRESS: 1000 Brantly Ave

VS 150

92

G78777 X 54.3 G78777

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): June L. Jenkins. A71552
2. DATE OF DEATH: OCT 8 - 1949
3. PLACE OF DEATH: a. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. 0 Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dayton
D. STREET ADDRESS (If rural, give location): Box 222

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | | 1-30-49 | | 8 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Eldridge Jenkins
14. MOTHER'S MAIDEN NAME: Juanita Fuss
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease
DUE TO Tricuspid atresia, post operative
Patent foramen ovale
(B) Interventricular septal defect.
DUE TO Pulmonary edema
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2- 1949 *to* 10-8- 1949 *that I last saw the deceased alive on* 10-8- 1949, *and that death occurred at* 2.30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: William W. Wang M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 10th 1949
24C. NAME OF CEMETERY OR CREMATORY: Rockingham Co.
24D. LOCATION (City, town, or county) (State): Va.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 1949
REGISTRAR'S SIGNATURE: Thurlington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS: Lindsey & Sons - Earl C. Vaught Harrisonburg, Va. 157E

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Correct age is especially important.

078778

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 078778

1. NAME OF DECEASED (Type or Print) Elmer Cross

2. DATE OF DEATH 10-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN Square Hosp.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) West Minister
D. STREET ADDRESS (If rural, give location) 43 Union St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widowed | 11-16-1865 | 82 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jerry Cross

14. MOTHER'S MAIDEN NAME Warfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Owens. Westminster Md ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B) Rt sided hemiplegia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/27/49, 19, to 10/8, 1949 *that I last saw the deceased alive on* 10/8, 1949 *and that death occurred at* 4 PM *from the causes and on the date stated above.*

23A. SIGNATURE J. Fred Hawkins Jr. M. D.

23B. ADDRESS Franklin Square Hosp.

23C. DATE SIGNED 10/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 11. 1949

24C. NAME OF CEMETERY OR CREMATORY Elsworth Cemetery

24D. LOCATION (City, town, or county) Westminster (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 9 1949

REGISTRAR'S SIGNATURE [redacted] Washington Millington Md

25. FUNERAL DIRECTOR J. E. Myers Jr.

ADDRESS Westminster Md.

83B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

078779

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

078779

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Augusta York

2. DATE OF DEATH: 10/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1501 Riverside Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1501 Riverside 2-04

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 23, 1882
9. AGE (In years last birthday): 67 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Druschel
14. MOTHER'S MAIDEN NAME: Johanna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Augusta Wall ADDRESS: 1501 Riverside

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 1 year |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertension | 1 year |
| DUE TO | Arteriosclerosis | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Nephritis | 3 days |

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): N
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September 1, 49 *to* October 6, 49 *that I last saw the deceased alive on* 10/5/49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Isaac Butler, M. D.
23B. ADDRESS: 122 S. Charles St
23C. DATE SIGNED: 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/10/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
24D. LOCATION (City, Town, or County) (State): E. End of North Ave

DATE RECEIVED BY LOCAL REGISTRAR: OCT 8 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: John F. Kenny Inc
ADDRESS: 715 Light St

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78780

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

40.0

G78780

Registered No.

1. NAME OF DECEASED (Type or Print): Maybelle Jones.

2. DATE OF DEATH: Oct 7 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 832 Edmondson ave. 17-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female. | Negro. | widowed. | | 50 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage from Gastric Peptic Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 4 days.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive cardio-vascular disease.-

19A. DATE OF OPERATION: None.
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 26, 1949, *to* Oct 7, 1949 *that I last saw the deceased alive on* Oct 7, 1949 *and that death occurred at* 7:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: H Patterson Mack. M. D.
23B. ADDRESS: University Hospital, Balto Md
23C. DATE SIGNED: Oct. 8 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-11-49
24C. NAME OF CEMETERY OR CREMATORY: St Peters
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. James A. Hemsley & Bidden
ADDRESS: 373

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1170

G78781 ✓ G78781

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mary E. Liggie Sampson

2. DATE OF DEATH 10-2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1010 N. Arlington Ave

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 16-01

D. STREET ADDRESS (If rural, give location) 1010 N. Arlington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | W. | 4-27-65 | 84 | 5 | 10 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Jackson Turner

14. MOTHER'S MAIDEN NAME Elizabeth Copper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT Edith Harris ADDRESS 1010 N. Arlington Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio-Vas-Disease — ? 

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Aug 12, 1949, *to* Oct. 7, 1949, *that I last saw the deceased alive on* Oct. 7, 1949, *and that death occurred at* 7A m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry McDonald M. D.

23B. ADDRESS 844 N Carey Balto. Md

23C. DATE SIGNED 10/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B.

24B. DATE 10-10-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary

24D. LOCATION (City, town, or county) (State) A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Samuel W. Sullivan Jr ADDRESS 1011 N. Arlington Ave 931

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78782 ✓X 40.1 G78782

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Sister Ita (Kenna)

2. DATE OF DEATH: 10/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2025 W. Fayette St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: 16 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B COUNTY: Philadelphia
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 44Th & Haverford Sts.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8/30/85
9. AGE (In years last birthday): 64 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious
10B. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mother Helena - Bon Secours Convent ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia (rt. lung) — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.
DUE TO
(B) Possible pulmonary embolism?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9/29/49
19B. MAJOR FINDINGS OF OPERATION: Perforated pyloric ulcer
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 5, 1949, to Oct. 7, 1949, *that I last saw the deceased alive on* Oct 7, 1949, *and that death occurred at* 3:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul B. Marrin M. D.
23B. ADDRESS: Bon Secours Hospital
23C. DATE SIGNED: 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-10-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY REGISTRAR: OCT 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Stanley Funeral Service ADDRESS

VS 150 VC & 92

117a

Please write clearly with pen and ink. Information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Statement of facts relating to cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 10/21/49

G78783

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78783

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Esther Harris Northwood

2. DATE OF DEATH: October 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Andrew Rurgug Home 3605 Hilledale Road

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 6911 Dunmanway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years, last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | M. | March 8, 1883 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Johnstown, Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Harris

14. MOTHER'S MAIDEN NAME: Mary A. James

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: John A. Northwood, Dundalk, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic Heart disease (Decompensated) — INTERVAL BETWEEN ONSET AND DEATH: 3 Mon.

DUE TO

(B)

DUE TO

(C) Acute Cardiac failure. — 10 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 27, 1949, *to* Oct 7, 1949, *that I last saw the deceased alive on* Oct 7, 1949, *and that death occurred at* 12 00 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis L. Warren M. D. | 2604 Garrison Blvd | 10-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10, 1949 | Greenlawn Cemetery | Johnstown, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| OCT 9 1949 | Curtis G. Williams, M.D. | Roland L. Fisher, 210 Dundalk Ave |

VS 150

95 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78784

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 4

G78784

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Barbara M. George

2. DATE OF DEATH Oct 7th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1329 N. Milton Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1329 N Milton Ave E 03

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug 21st 1886
9. AGE (In years last birthday) 63
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Max Walter
14. MOTHER'S MAIDEN NAME Margaret Goeller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. N. George 1329 N. Milton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease — (INTERVAL BETWEEN ONSET AND DEATH) apprx 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension, uncertified — unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 Nov 1946, *to* 9 Oct 1949, *that I last saw the deceased alive on* 20 Oct 1949, *and that death occurred at* 4.20A *m., from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.
23B. ADDRESS 1513 N. Milton Ave
23C. DATE SIGNED 8 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 10th 1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Belair Road

DATE RECEIVED BY LOCAL REGISTRAR OCT 9 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Leo. G. Leach
ADDRESS 1703 N. Patterson Park Ave

VS 150

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78785

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78785

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Harry Edward Dunn

2. DATE OF DEATH: October 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1707 N. Collington Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | July 20, 1902 | 47 | 2 17 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Not any YARD CLERK RAILROAD
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Bernard E. Dunn
14. MOTHER'S MAIDEN NAME: Catherine M.Barry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr.Bernard E. Dunn ADDRESS 4618 Harcourt Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B) Hypertension & arteriosclerosis
DUE TO
(C) Dissecting aneurism of aorta

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* 9/25/ , 1949 *to* 10/7/ , 1949, *that I last saw the deceased alive on* 10/7/ , 19 49 *and that death occurred at* 11:15 AM *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Swoniski M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 10/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10 10 49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 9 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Elmer W.Conklin ADDRESS 924 E.Eager St.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78786

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4 12 — G78786 — Registered No.

1. NAME OF DECEASED (Type or Print): Jacob J. Stailey

2. DATE OF DEATH: Oct 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5440 Belair Rd Gardenville Convalescent Home

C. Length of stay in Baltimore: 9 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore E. Md
D. STREET ADDRESS (If rural, give location): 5444 Belair Rd 27-24

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 18 1858
9. AGE (In years last birthday): 91 — If Under 1 Year: Months 2, Days 20 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Stailey
14. MOTHER'S MAIDEN NAME: Harriet Shoemaker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs Margaret M Sergent ADDRESS: West P.O.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Arteriosclerosis; senility — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cardio-vascular renal syndrome

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 5, 1949 to Oct. 8, 1949 that I last saw the deceased alive on Oct 7, 1949, and that death occurred at 10:25 p m., from the causes and on the date stated above.

23A. SIGNATURE: R. L. Harbold, M. D.
23B. ADDRESS: 4706 Harford Road
23C. DATE SIGNED: 10-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-10-1949
24C. NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery
24D. LOCATION (City, town, or county) (State): Liverpool Pa.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elmer W. Conklin ADDRESS

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

121a

To be approved by chief medical examiner

078787

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 170: 0

Registered No. 078787

1. NAME OF DECEASED (Type or Print): Emma Johnson

2. DATE OF DEATH: October 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 308 E. Hamburg St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | Unknown | 73 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ? Andrews
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Husband - Elvin Johnson ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized arteriosclerosis and Heart disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

CERTIFICATION APPROVED BY
For: Wm. G. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Fracture rt. hip
Fracture rt. pubis

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 308 E. Hamburg St.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 4th AM 9-3-49 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Fell From window

24/3

22. *I hereby certify that I attended the deceased from* Sept 3, 1949, to Oct 5, 1949, *that I last saw the deceased alive on* Oct 5, 19 49 *and that death occurred at* 5 00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jerome Plest M. D.
23B. ADDRESS: So. Balto. Gen'l Hosp
23C. DATE SIGNED: 10-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 10. 1949
24C. NAME OF CEMETERY OR CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Edmondson Ave

DATE RECEIVED BY LOCAL REGISTRAR: OCT 9 - 1949
REGISTRAR'S SIGNATURE: Tuttle for Williams, MD
25. FUNERAL DIRECTOR: Wendell L. Rippel ADDRESS:

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

186a

G78788

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78788

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles C. Seifert

2. DATE OF DEATH: Oct. 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto. City Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 333 Washburn Ave.
c. Length of stay in Baltimore: 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 333 Washburn Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 12-2-1871 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman Rigger | Ship Building | Germany | U.S.A. |

13. FATHER'S NAME: Frank Siefert

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Ellen V. Seifert 333 Washburn Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO
(B) Arterio - Sclerotic Cardio-Vascular
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* Oct. 6, 1949, *that I last saw the deceased alive on* Oct 4, 1949, *and that death occurred at* 4.15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Lubin M.D. | 320 Wagner Ave | 10/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-10-1949 | Holy Cross | A.A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 9 - 1949 | [illegible] | Flynn & Fleming 1426 Light St. |

VS 150

496 4V

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78789

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78789

BIRTH NO.

1. NAME OF DECEASED (Type or Print) [illegible] Jane Meyer Gundersdorf

2. DATE OF DEATH Oct. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 14 East 21st. St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore 29 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 14 E. 21st St. 12-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 10-17-19 | 29 | 11 / 20 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Stanley Overton
14. MOTHER'S MAIDEN NAME: Ethel Meyers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 220-09-6054
17. INFORMANT: Ralph J. Gundersdorf ADDRESS: 14 E. 21st St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Husband)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Pulmonary Tuberculosis. | 9 yrs |
| DUE TO | | |
| (B) | Mitral Stenosis Pulmonary Tuberculosis | 1 yr 1 day |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15th, 1949, *to* Oct. 8th, 1949, *that I last saw the deceased alive on* Oct 7th, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.
23B. ADDRESS 1300 N. Calvert St
23C. DATE SIGNED Oct 8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 10, 49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Ellsworth [illegible] ADDRESS: 5118 Gwynn Oak Ave.

VS 150

13B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G 78790

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. G 78790

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maria D Maistros.

2. DATE OF DEATH: Oct 6th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1415 N. Decker Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: M. D.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03
D. STREET ADDRESS (If rural, give location): 1415 N. Decker ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | White | widowed | | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Greece | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Costaris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Peart Ranges — ADDRESS: 1415 N. Decker Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-

DUE TO

ANTECEDENT CAUSES

(B) vascular Heart disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO with heart failure.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) yea[illegible]

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 19[illegible]8, *to* 10-6, 1949, *that I last saw the deceased alive on* 10-4, 1949, *and that death occurred at* 12 30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Chelsea L Yeanoz M. D.

23B. ADDRESS: 3025 Belair Road

23C. DATE SIGNED: 10-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10-10-1949

24C. NAME OF CEMETERY OR CREMATORY: Greek Cemetery

24D. LOCATION (City, town, or county) (State): Windsor Mill Rd.

DATE RECEIVED BY LOCAL REGISTRAR: Oct 10, 1949

REGISTRAR'S SIGNATURE: Thurlington for Baltimore, Md.

25. FUNERAL DIRECTOR: Lambros Inc — ADDRESS: 440 E. North Ave

VS 150

931D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78731 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78731 Registered No.

1. NAME OF DECEASED (Type or Print): LEONARD C. EHRLINGER
2. DATE OF DEATH: 10/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTO. GENERAL HOSP.
c. Length of stay in Baltimore: 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~BA~~ 22 S. ELLWOOD AVE
D. STREET ADDRESS (If rural, give location): 1-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | Nov. 19-1876 | 72 | 10 | 20 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CLERK | Retired BANK | Penna. | |

13. FATHER'S NAME: George Ehrlinger
14. MOTHER'S MAIDEN NAME: Margaretta Fisher

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | None | Mrs. Etta K. Ehrlinger | Ellwood 22 S. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) GAINGRENE OF COLON
DUE TO
(B) MESENTERIC THROMBOSIS
DUE TO
(C) MURAL THROMBOSIS OF ATHEROSCLEROTIC AORTA

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* OCT 7, 1949, *to* OCT 8, 1949, *that I last saw the deceased alive on* OCT 8, 1949, *and that death occurred at* 7 45 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William B. Cooper Jr M.D. | South Balto Gen Hosp | 10/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | Oct 11 49 | Baltimore | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Function for Williams, M.D. | Philip Herwig Sons | Orleans at |

VS 150 -66 8V

123

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G78792 G78792

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 143

1. NAME OF DECEASED (Type or Print): Katherine Bronikowski

2. DATE OF DEATH: Oct. 7/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1612 Fleet St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1612 Fleet St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1612 Fleet St. 2-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House work | At home | Poland | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Frank Bronikowski 1612 Fleet St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Renal

DUE TO

(B) Cerebral Softening

DUE TO

(C) Cerebral Arthrosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* June, 1949, *to* Oct 7, 1949, *that I last saw the deceased alive on* Oct 7, 1949, *and that death occurred at* 7:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Helen J. Zaworski M.D. | 2711 Eastern Ave | Oct 8, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 11/49 | Holy Cross | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Turlington Williams M.D. | Fred W. Ozarowski | 1930 E. Monument Ave. 93D |

VS 150

Cross out words not applicable. Physician: please write the cause of death clearly and legibly.

MS-132356
G78793

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

146 Registered No. G78793

1. NAME OF DECEASED (Type or Print): Mary M. Smith

2. DATE OF DEATH: 10-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 930 Pierce St. Zone 23 18-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Married | June 18, 1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: John H. Lee

14. MOTHER'S MAIDEN NAME: Mary Jefferson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S NAME AND ADDRESS |
|---|---|---|---|
| | | | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Malignant Nephrosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertensive cardiovascular Disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-4-, 1949, *to* 10-7-, 1949 *that I last saw the deceased alive on* 10-7-, 1949, *and that death occurred at* 3:55P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Cooper M. D. | Baltimore City Hospitals | 10-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 12-49 | Mt Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, MD | James A Hayes | 638 N. Belnor St |

VS 150

131a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78794

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78794

1. NAME OF DECEASED (Type or Print): ANTHONY I HERR

2. DATE OF DEATH: 10/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2919 W. North Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2919 W. North ave. 15 26

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Dec 18 1867 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Dealer | Scrap metal | Md. | |

13. FATHER'S NAME: LEOPOLD HERR

14. MOTHER'S MAIDEN NAME: ANNA RUHL

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Joseph Herr | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Cardio-vascular disease — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 29, 1949 *to* Oct 8 49, 19__, *that I last saw the deceased alive on* Oct 7, 1949, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter D. Burnett M. D. | 22 20 Garrison Blvd | Oct 9 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/ /49 | Cathedral | Wisto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Mac Nabb & Son | 92D Catonsville Md |

VS 150

15660

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78795

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G78795

1. NAME OF DECEASED (Type or Print) MILEN DIVICH

2. DATE OF DEATH October 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

C. Length of stay in Baltimore 15 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3701 Fairmont Avenue 26-44

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Dec. 28-1910 | 38 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker

10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co

11. BIRTHPLACE (State or foreign country) Ohio

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Theodore Divich

14. MOTHER'S MAIDEN NAME Helen — Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 194-05-5143

17. INFORMANT Bertha Ronos ADDRESS Chester Pa.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Oct. 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 10-49

24C. NAME OF CEMETERY OR CREMATORY Prospect Meth. Cem.

24D. LOCATION (City, town, or county) Balto., Md (State)

DATE RECEIVED BY LOCAL REGISTRAR OCT 10 1949

REGISTRAR'S SIGNATURE Huntington Williams, MD

25. FUNERAL DIRECTOR John G. Connelly ADDRESS 418 Eastern Ave Balto 21 Md

VS 151 49629 940

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C78796

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C78796

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bessie E. Hart

2. DATE OF DEATH: Oct. 7th. 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
353 Rosebank Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mrs. Rhodes Nursing Home

C. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 405 E. 22nd. St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | Widow | May 24th. 1874 | 75 | 4 | 13 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. Walker

14. MOTHER'S MAIDEN NAME: Rhoanna Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Miss Helen Hart, 405 E. 22nd. St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

DUE TO

(B) Endocarditis — unknown

DUE TO

(C) none

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 8th. 19 49, *to* Oct. 7th. 19 49, *that I last saw the deceased alive on* Oct. 6th. 19 49, *and that death occurred at* 11:30A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. W. Mongatroyd M.D.

23B. ADDRESS: 401 E. 25th. St. Balto. Md.

23C. DATE SIGNED: 10/9/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/10/49

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949

REGISTRAR'S SIGNATURE: Huntington Nicholson, MD

25. FUNERAL DIRECTOR: E J Fanning & Son - 1938 E. Lafayette Ave

ADDRESS

VS 150

92E

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78797
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

G78797
Registered No.

1. NAME OF DECEASED (Type or Print): PLUMMER GILLIAM (emw)

2. DATE OF DEATH: Oct. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1204 N. Caroline St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1204 N. Caroline St. 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Married | May 6, 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Building Ind. | Farmville Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| unknown | unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mary Gilliam | 1204 N. Caroline St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute dilatation of heart — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive C.V. Disease.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Paul L Boyer M.D. | | Oct 7 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Oct 11 49 | | Farmville Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Mrs. Robert G. Elliott Sr. | 937 1129 N. Caroline St. |

VS 151

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G78798

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163 Registered No. G78798

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Allen

2. DATE OF DEATH: Oct-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL Dal 2
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 641 N. Eutaw St.

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep
8. DATE OF BIRTH: 1893
9. AGE (In years last birthday): 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer, Contractor
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jack Allen
14. MOTHER'S MAIDEN NAME: Lilly Harris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: 9 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19-, 1949 *to* 10/8/, 1949 *that I last saw the deceased alive on* 10-8-, 1949 *and that death occurred at* 12.50 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip D. Negley M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 14/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): AA County Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Mrs Robert G. Elliott & Daughter
ADDRESS: 1120 N. Carlton St

VS 150

Get V9

47D

AB-131829
G78799

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78799

1. NAME OF DECEASED (Type or Print): Abraham Potts

2. DATE OF DEATH: 10-7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 12years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jessup
D. STREET ADDRESS (If rural, give location): Rt. 1-Box 112-Washington Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Widowed | June 8- 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Pa. | |

13. FATHER'S NAME: Joseph Potts (D

14. MOTHER'S MAIDEN NAME: Sarah Hazzard (D

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Baltimore City Hospitals Records: ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Cancer of the Adrenal Gland
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9-13 19~~49~~ 48 *to* 10-7 19 49 *that I last saw the deceased alive on* 10-7 19 49 *and that death occurred at* 12.45 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Rogers M. D. | Baltimore City Hospitals | 10-7-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Oct 11 1949 | | West Chester Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Mrs Robert A. Elliott & Daughter | 55a 1129 N. Carlton St |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78800 49-13543 BALTIMORE CITY HEALTH DEPARTMENT 76 3.0 G78800

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Michael S. Turner

2. DATE OF DEATH: Oct. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1226 McCulloh Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1226 McCulloh Street 11 04

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 22, 1949
9. AGE (In years last birthday): If Under 1 Year: Months 3, Days 16; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Turner
14. MOTHER'S MAIDEN NAME: Hattie Austin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hattie A. Turner ADDRESS: 1226 McCulloh St. Balt'md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4, 1949 *to* 10-8, 1949 *that I last saw the deceased alive on* 10-7 1949 *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Atwell Jones M.D.
23B. ADDRESS: 5-56 Dolfk St
23C. DATE SIGNED: 10-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 10, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn
24D. LOCATION (City, town, or county) (State): Westport, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles H. Alexander ADDRESS: 1200 McCulloh St. Baltimore

VS 150

107

D. C. Ref. No. 12521 ✓ 756 ✓ 078801

078801

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): James B. Kelly

2. DATE OF DEATH: Oct. 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26 06
D. STREET ADDRESS (If rural, give location) 6820 Germon Mill Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 6/13/48 | 1 | 3 4 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James E. Kelly

14. MOTHER'S MAIDEN NAME Anna May Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Biliary Atresia

DUE TO

(B)

DUE TO

(C)

CERTIFICATION APPROVED BY
B&Drake
per: C.J.Lubinski, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/9 19 49 *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 12 20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Harrison C. Flowers M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 10-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10-11-49

24C. NAME OF CEMETERY OR CREMATORY Oak Lawn

24D. LOCATION (City, town, or county) Dalto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 10 1949

REGISTRAR'S SIGNATURE [illegible] for Baltimore, Md

25. FUNERAL DIRECTOR Jack Reaves Inc ADDRESS 2100 Eutaw Pl

VS 150

To be approved by Med Examiner 1579

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78802

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450

G78802

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): SARAH MOYER

2. DATE OF DEATH: 10-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2023 Clifton Ave
C. Length of stay in Baltimore: 49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2023 Clifton Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 63
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alex
14. MOTHER'S MAIDEN NAME: Miriam

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Ida Moser ADDRESS: 2023 Clifton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) chron. Rheumatoid arthritis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO

(B) arterio Sclerotic vascular disease — 3 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-25-45, *to* 10-8-49, *that I last saw the deceased alive on* 10-6-49, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. G. Nicholson M. D.
23B. ADDRESS: 2230 Eutaw Pl.
23C. DATE SIGNED: 10-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-10-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, Town, or County) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

93 c

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

G78803 Blow ✓ 001 G78803

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katie Blow (HUNTER) | 2. DATE OF DEATH: 10-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 539 Oxford St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 539 Oxford St. 17-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | WIDOWED | July 26 1905 | 43 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waitress | Cafe | Balto. Md. | U.S.A. |

13. FATHER'S NAME: William A. Hunter
14. MOTHER'S MAIDEN NAME: Jennie Doughty

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William A. Hunter | 552 Wilson St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Carl L. Rose M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 10 ✓ 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-12-49 | Mt. Auburn Cemetery | A.A. Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: William A. Jackson Funeral Home ADDRESS 876

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7877 13B

G78804

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78805

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Frank H Resch

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location): Montgomery Rd.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mch. 15, 1884
9. AGE (In years last birthday): 65 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: John RESCH
14. MOTHER'S MAIDEN NAME: Margaret ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Mrs Herman C'Neil, ADDRESS: Ellicott City, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIO SCLEROTIC CARDIO-
DUE TO VASCULAR DISEASE E
(B) ACUTE CARDIAC FAILURE
DUE TO
(C) UREMIA

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/7, 1949 to 10/9, 1949 that I last saw the deceased alive on 10/9, 1949, and that death occurred at 1:25 m., from the causes and on the date stated above.

23A. SIGNATURE: John F. Shaw M. D. | 23B. ADDRESS: [illegible] | 23C. DATE SIGNED: 10/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 10-11-49 | 24C. NAME OF CEMETERY OR CREMATORY: St Marys | 24D. LOCATION (City, town, or county) (State): Alchester Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: F.C. Hyndman Sons, ADDRESS: Ellicott City, Md

VS 150

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78805

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78805

Registered No.

1. NAME OF DECEASED (Type or Print) EDWARD REINDOLLAR

2. DATE OF DEATH October 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 257 W. 31st Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | SINGLE | NOV 20, 1910 | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PIPE FITTER | SHIPYARD | MARYLAND | U. S. |

13. FATHER'S NAME
EUGENE M. REINDOLLAR

14. MOTHER'S MAIDEN NAME
CATHERINE MINES

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | 2ND W. W. | | CATHERINE REINDOLLAR | 257 W 31st St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage.
DUE TO
(B) Hypertension.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE Emil L. Rogers M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED October 8, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 11/49 | New National | Frederick Rd Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Austin E. Bonvaue — ADDRESS: 3818 Poland Ave

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

832a

CERTIFICATE CORRECTED 10-14-49

G78806 132415

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78806

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Howard Sprucebank

2. DATE OF DEATH: 10- 8- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2827 Hampden ST. Z 11 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 12-5-1879 ~~Dec. 7 1879~~ | 69 Yrs 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tinner

10B. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: (D) George W. Sprucebank

14. MOTHER'S MAIDEN NAME: (D) Salina A. DeBaugh ~~Salinan A. DeBaugh~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT SALINA ADDRESS: B.C.H. Records 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Vascular Accident | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive Arteriosclerotic Cardiovascular Disease | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10- 6- , 1949 *to* 10- 8- , 1949 *, that I last saw the deceased alive on* 10- 8- , 1949 *and that death occurred at* 7.20PM. *from the causes and on the date stated above.*

23A. SIGNATURE: H. A. Cozen M.D.

23B. ADDRESS: B.C.H. 4940 Eastern Ave.

23C. DATE SIGNED: 10- 8- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct 11/49

24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Homedale

24D. LOCATION (City, town, or county) (State): Poland Ave Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Eustin E. Donovan

ADDRESS: 3818 Poland ave

VS 150

93D

G78807

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78807

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Walter Mason

2. DATE OF DEATH: Oct. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospt 2025 W Fayette St
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3413 University Place
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 12-0
D. STREET ADDRESS (If rural, give location): 3413 University Place

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec 14 1893 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Building Supt | Construction Co | Baltimore Md. | U.S.A. |

13. FATHER'S NAME: Randolph Bradford
14. MOTHER'S MAIDEN NAME: Francis Pessell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| None | None | 215-09-6981 | Mary E. Mason | 3413 University Place |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Hemothorax
DUE TO
(B) Erosion in Mediastinum
DUE TO
(C) Carcinoma Esophagus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Empyema - Peritonitis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 8/23/49 | Carcinoma Esophagus & Cardia | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/21/ 1949 *to* 10/8/ 1949 *that I last saw the deceased alive on* 10/8/ 1949, *and that death occurred at* 5:45 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. Krahler M. D. | Bon Secours Hosp. | 10/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 12 1949 | Woodland Memorial Parks | Taylor Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | John C. Moran | 3000 E Baltimore St |

VS 150

12-7-49

46a

*Correct age is especially important. Physicians: please write the causes of death clearly and legibly.*

078808

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 078808

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE MITCHELL

2. DATE OF DEATH October 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
116 St. Johns Road

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2034 Druid Hill Avenue 14-03

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | Married | Jan. 6, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| domestic | | Virginia | U.S.A. |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Rev. John Mitchell — ADDRESS: 2034 Druid Hill Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary occlusion | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Carl L. Boyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED October 7, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10, 1949 | Mt. Auburn | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home, 1631 Druid Hill Ave.

VS 151

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78809

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78809

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Beasley Hicks

2. DATE OF DEATH: Oct. 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1632 Edmondson Ave.

c. Length of stay in Baltimore: 40 years. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1632 Edmondson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | Dec. 25 1879 | 69 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Insurance Agent | Insurance | Mecklenberg Co. Va | U.S.A. |

13. FATHER'S NAME: Samuel Edward Hicks

14. MOTHER'S MAIDEN NAME: Nancy Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Cecelia Hicks ADDRESS: 1632 Edmondson Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | | YES ☐ NO ☐ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 5/28/49 to 10/8/49, that I last saw the deceased alive on 10/8/49, and that death occurred at 5:30 P.m., from the causes and on the date stated above.

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| [redacted] M. D. | 450 W. Biddle St | 10/13/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12, 1949 | Arbutus Mem. Pk. | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. 52B |

VS 150

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acc Room
D.O.A.

G78810

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78810

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Doak Cash — 2. DATE OF DEATH: OCT 5 - 1949

3. PLACE OF DEATH: x Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Md; b. COUNTY; c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore; d. STREET ADDRESS (If rural, give location): 831 N. Wolf St

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 7 Mos. Days 4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | Oct 20-1902 | 46 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | S.C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Dan Cash | Lollie Gaus |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: Minutes
DUE TO Site undetermined
(B) Hypertensive Cardio-Vascular disease — Years
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Wm. H. Hammer, M.D.
Per D.H. Fraber M.D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* D.O.A. 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Sukeus M.D. | JOHNS HOPKINS HOSPITAL | 10-6-46 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 10-49 | Mt Calvary Cem | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Bentley Ave |

VS 150

To be approved by Medical Examiner 93

G78811 ✓ 150 0 G78811

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HENRY HUTH

2. DATE OF DEATH: Oct. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 417 S. Chapel Gate Lane
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 417 S. Chapel Gate Lane 2 - 21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 18, 1865 | 83 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| General Mgr.(Rt'd) | Meat Packing | Schlitz Germany | |

13. FATHER'S NAME: Jeremiah Huth

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Miss Marie Huth | 417 S. Chapel Gate Lane |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Dilitation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Arterio Sclerosis — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept, 1946 *to* Oct 6, 1949 *that I last saw the deceased alive on* Oct 6, 1949, *and that death occurred at* 5.25 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Shusman M. D. | 2687 Wheeler Ave | Oct 7, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/49 | Loudon Park Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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G78812

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 81-10 G78812 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Andrew B. Boyd — N-803-7 — 2. DATE OF DEATH: Oct. 8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp.
C. Length of stay in Baltimore: Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1029 Rutland Ave 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Child | Jan 5-1943 | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School | | Baltimore Md | U.S.A. |

13. FATHER'S NAME: Robert Boyd
14. MOTHER'S MAIDEN NAME: Doris Brown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Doris Boyd | 1029 Rutland Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH ☐ | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | street | Chase St. just west of Rutland Ave. |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 8, 1949 11.20 a m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Pedestrian struck by trailer truck |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Royer M.D. | | 10-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12-49 | Prot. Calvary Cem. | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Bentley |

.170c

GH 132198
G78813

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78813 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY Frances Hamilton

2. DATE OF DEATH: 10- 7- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 20-06
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3129 Leeds St.
~~Crownsville State Hospital~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widowed | April 21 1882 | 67 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MD. | |

13. FATHER'S NAME: Moses Hughes

14. MOTHER'S MAIDEN NAME: Annie Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: B.C.H. Records 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gangarene Of Right Foot
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct. 5- 1949 | Gangarene Right Foot | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9- 28- , 1949, *to* 10- 7- , 1949 *that I last saw the deceased alive on* 10- 7- , 1949 *and that death occurred at* 8½ 20 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Rogers M. D. | 4940 Eastern Ave. | 10- 7- 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10/12/49 | Western Star Cemetery | Catonsville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, MD | H. Halstead | 918 Druid Hill Ave |

VS 150

98

G78814

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

H 90

G78814

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosie Foskey

2. DATE OF DEATH: Oct 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 312 Myrtle Avenue

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 312 Myrtle Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | May 26, 1930 | 19 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | | Maryland | U. S. A. |

13. FATHER'S NAME: Garland Foskey

14. MOTHER'S MAIDEN NAME: Mary Blackson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | | Mary Foskey - 312 Myrtle Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

(B)

DUE TO

(C) M. Intestinum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 22 1949 *to* Oct 6 1949, *that I last saw the deceased alive on* Oct 5, 1949, *and that death occurred at* 10:45 am *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Cannon M. D. | 253 Court | 10/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/49 | Mt Auburn Cemetery | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | A. Halstead - 918 Druid Hill Ave |

VS 150

108

G78815

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78815

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES FREMONT VODERY

2. DATE OF DEATH: Oct 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2329 McCulloh Street
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2329 McCulloh Street 13-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | C | Married | 6/9/1890 | 59 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motion Picture Operator
10B. KIND OF BUSINESS OR INDUSTRY: (Theater)

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Vodery
14. MOTHER'S MAIDEN NAME: Lucy Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 217-03-8926
17. INFORMANT: Alice Vodery ADDRESS: 2329 McCulloh Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | aortic Insufficiency + anemia | 5 years |
| DUE TO | Hypertension | ? |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Nephrosis | 6 months |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-15- 1949 *to* 10-6- 1949 *that I last saw the deceased alive on* 10-6- 1949, *and that death occurred at* 10 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis E. Harmon, M. D.
23B. ADDRESS: 2224 Madison Avenue - 17
23C. DATE SIGNED: 10-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/10/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Anne Aurendel Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles R. Law ADDRESS: 802 Madison Ave - 1

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 53

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Anna Thornton**

2. DATE OF DEATH **Oct. 7/49**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **General German Aged Peoples Home, 22 S. Athol Ave.**

C. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **22 S. Athol Ave.** 28-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| **Female** | **White** | **Widow** | **Jan. 4, 1875** | **74** | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **None** | | **Baltimore, Md.** | ✓ |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| **Jacob Assman** | **Anna Filing** |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT **Son** ADDRESS **Edwin F. Thornton, 525 Winston Ave.** |
|---|---|---|

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Arcinoma of Intestines** — Interval between onset and death: **Unknown.**

DUE TO

(B)

DUE TO

(C) **Broncho-Pneumonia**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* **June 10/49** 19__, *to* **Oct. 8/49** 19__, *that I last saw the deceased alive on* **Oct. 3/49** *and that death occurred at* **2 P.** *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **Henry Hardy Chenoth.** M. D. | **430 Hanover (21)** | **Oct. 10/49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Oct. 10/49** | **Woodlawn** | **Woodlawn, Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Penrington for Williams, M. | Harry H. Leitzfie | **4101 Edmondson Ave.** |

VS 150

46E

G7881:7

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

G7881:7

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret E Miller

2. DATE OF DEATH: Oct. 7. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3703 Harlem Ave 16 08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | White | married | NOV. 1 1904 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | md. | |

13. FATHER'S NAME: JESSE STAUBS

14. MOTHER'S MAIDEN NAME: MARY

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (SISTER) ADDRESS |
|---|---|---|
| | | MRS KATHRYN SCERS - 423 N. BRICE ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL VASCULAR ACCIDENT RIGHT - PROBABLY

DUE TO

(B) HEMORRHAGE

DUE TO

(C) HYPERTENSIVE CARDIO - VASCULAR DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/28, 1949 *to* 10/7, 1949 *that I last saw the deceased alive on* 10/7, 1949 *and that death occurred at* 9:15 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | [illegible] | 10/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | OCT 11 1949 | HOLY REDEEMER | BALTIMORE, MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | HARRY H WITTKE | 4101 EDMONDSON AVE |

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G78818 G78818

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET M. RYAN

2. DATE OF DEATH Oct. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen Hosp.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1738 Braddish Ave. 15-06

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | single | 10/7/1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housework | at home | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME Louis B. Ryan,

14. MOTHER'S MAIDEN NAME Mary Dempsey.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | Mr. John E. Ryan, 1738 Braddish Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO. VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) GENERALIZED ARTERIOSCLEROSIS

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/30/49 *to* 10/9/49, *that I last saw the deceased alive on* 10/8/49, *and that death occurred at* 10:15 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | W B G H | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/11/49 | Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | [signature] | 4611 Park Heights Ave. |

VS 150

61

G78813

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78813

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MISEK, ANTOINETTE

2. DATE OF DEATH: 10/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2001 Bank St. #31

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | — | 90 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | CZECH | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Rungie | |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Joseph Misek 2001 Bank St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C) Fracture of Left Hip

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | at residence 2/1 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10/6/49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fell getting out of bed. |

22. *I hereby certify that I attended the deceased from* 10/10/49 *to* 10/10 19 49 *that I last saw the deceased alive on* 10/10 19 49 *and that death occurred at* 8 39 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Leonard Dener M. D. | Sinai Hospital | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 13-49 | Holy Redeemer | Balto. City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 10 1949 | Hunter for Williams, M.D. | Wm. S. Fialkowski |

VS 150

186a

G78820 D-80564

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

089

Registered No. G78820

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Caroline Ford

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-0
D. STREET ADDRESS (If rural, give location): 4327 Belair Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | 6/6/47 | 2 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Ford
14. MOTHER'S MAIDEN NAME: Irene Wieczorkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Ford ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Inanition, Cachexia — 12 mos

DUE TO

(C) Mumps Encephalitis — 12 mo.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/26, 1949 *to* 10/9, 1949, *that I last saw the deceased alive on* 10/9, 1949 *and that death occurred at* 1:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas E. Shuck M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 10/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 11-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Thurlington for Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 2007 Eastern Ave.

VS 150

44c

G78821

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9135 G78821

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS J. BROWN — N-6150

2. DATE OF DEATH: Oct. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 7011 Belona Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | June 13 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Advertising | Baltimore | |

13. FATHER'S NAME: Thomas J. Brown

14. MOTHER'S MAIDEN NAME: Isabelle Ruff

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (ADDRESS) |
|---|---|---|
| Yes — World war 1 | 022-01-3654 | Mrs. Hilda A. Brown — ~~7011 Bellona Ave.~~ |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage
DUE TO
(B) Rupture of Spleen, traumatic
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | public | Vine St., between 11th and 12th St. Philadelphia, Pa. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Oct. 2, 1949 ? m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Alleged assault and robbery |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Koge M.D. | | 10-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-11-49 | New Cathedral | Baltimore Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949 — REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR — ADDRESS: Charles H. Evans & Son Inc. 118 N. Mt Royal Ave. 168

VS 151

G788822

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G788822

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josephine Ichniowski

2. DATE OF DEATH October 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1113 S. Ellwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1113 S. Ellwood Avenue 1-01

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

13. FATHER'S NAME: ? Ichniowski

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Veronica Lind, Daughter | 1113 S Ellwo |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Insuff. — acute

DUE TO

(B) Chronic Myocarditis - Chr. Hyper. 10 yrs + Chr. arteris - arterio sclerosis (senile)

DUE TO

(C) Senile Dementia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Jan. 49 to Oct. 7, 19 49, that I last saw the deceased alive on Oct 7, 19 49, and that death occurred at 12:30 a m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jane F. Stamples M. D. | 2002 E. Pratt St | 10/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/49 | Holy Rosary Cemetery | German Hill Road Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Mary Weber -401 S. Chester St. |

VS 150

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G78823

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78823

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clarence Neal

2. DATE OF DEATH: Oct. 7. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 26 N. Exeter Street

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 26 N. Exeter Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Married | July 23. 1917 | 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Seaman | Ship | Baltimore Md. | U.S.A. |

13. FATHER'S NAME: Clearence Neal

14. MOTHER'S MAIDEN NAME: Amy Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Elizabeth Neal 26. E.Spring St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-1, 1949 *to* 10-7, 1949, *that I last saw the deceased alive on* 10-7, 1949 *and that death occurred at* 12:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. C Burwell M. D. | 1 21 Aisquith | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 11. 1949 | Mt Calvery Cem. | Brooklyn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Elroy O. Wilson 1000 Brantly Ave. |

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13B

G78824 G78824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gregory J. Avara

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hill Crest Home

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-07
D. STREET ADDRESS (If rural, give location): 1169 Washington Blvd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 5/30/1933 | 16 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School Boy | | Baltimore Md. | U S A |

13. FATHER'S NAME: Vincent Avara

14. MOTHER'S MAIDEN NAME: Marie T. Cammarata

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mr Vincent Avara | 1169 Blvd Wash |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 10-9-49

DUE TO

(B) Post operation - Colectomy

DUE TO

(C) Ulcerative Colitis & Polyposis — 5-10-49.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 7-25-49 | Ulcerative Colitis-Polyposis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7-25- 19 49 *to* 10-9 19 49 *that I last saw the deceased alive on* 10-9 19 49 *and that death occurred at* 6:30 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L Bowman Jr. M. D. | 715 N. Charles St. | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | New Cathedral Cem. | 4300 Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | John J. Cowan & Son | 2 Collins St |

120 B

G78825

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78825

1. NAME OF DECEASED (Type or Print): Frederick Englebrecht

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 10 S. Fremont Ave

c. Length of stay in Baltimore: 45 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 10 S. Fremont Ave 16-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Divorced | 6/10/1890 | 59 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Box Maker | Monumental Paper Box Co. Inc. | Frederick Md. | U S A |

13. FATHER'S NAME: George G. Englebrecht

14. MOTHER'S MAIDEN NAME: Emma S. Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Nora Edith Basham ADDRESS: 10 S. Fremont

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cardiac Failure — | Immediate |
| DUE TO (B) | Cardio-Renal disease — | years. |
| DUE TO (C) | Cirrhosis of liver | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles Townsend M. D. | 900 W. Lombard St | Oct-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/12/49 | Mt Olivet Cem. | Frederick Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams | John J. Cowan & Son | 20 E. Lo[illegible] |

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NOVAK

G78826

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78826

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ignatius Novak

2. DATE OF DEATH: 10/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balt. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY Balt.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen. Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1810 Gough St 2 or

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | white | Widowed | | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Industrial work | | Poland | |

13. FATHER'S NAME: John Novak

14. MOTHER'S MAIDEN NAME: Catherine Schaganosk.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 213-10-0596 | Mary Marcinko | 1810 Gough St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — DUE TO

ANTECEDENT CAUSES

(B) Hypertrophy Prostate — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) — DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/24/49, 19 to Oct 8, 19 49, *that I last saw the deceased alive on* Oct 8 1949, *and that death occurred at* 10 1/4 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. E. Martin Md. M. D. | Maryland Gen. Hosp. | Oct 8, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12-1949 | St. Stanislaus | Balto. City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Wm. S. Fial Kowalski | 2007 Eastern Ave |

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G78827

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

446

Registered No. G78827

1. NAME OF DECEASED (Type or Print): HUGH MILES DEISE

2. DATE OF DEATH: 10/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-01
D. STREET ADDRESS (If rural, give location): 4511 Harcourt Rd #1L

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, (MARRIED) WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 6/16/99
9. AGE (In years last birthday): 50 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Loyal Ind Co
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Beatrice Deise ADDRESS: 4511 Harcourt

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic nephritis

DUE TO

(C) malignant hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/18, 1949, to 10/8, 1949, that I last saw the deceased alive on 10/8, 1949, and that death occurred at 8:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Charles J. Blanck M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 10/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-11-49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Pk
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford

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G78828

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78828

1. NAME OF DECEASED (Type or Print): William Stout

2. DATE OF DEATH: 10-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 N. Haven St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 108 N. Haven St. 26-44

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | October 25 1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Contenental Can | Nightwatchman | Balto. - Md. | |

13. FATHER'S NAME: Louis Stout

14. MOTHER'S MAIDEN NAME: Margaut Blowers

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes 6-19-17 to 2-14-19 | 205-01-8448 | Hilda C. Stout | 108 N. Haven St. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 hour |
| DUE TO (B) | Hypotension | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Chronic Pulmonary Emphysema | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Asthmatic Bronchitis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan. 20, 1948, to Oct. 7, 1949, *that I last saw the deceased alive on* Oct. 8, 1949, *and that death occurred at* 1:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John Constantine, M. D. | 234 S. Conkling St | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-12-49 | St. Matthews Cem | Balto. - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, MD | John C. Miller Inc. | 2435 E. Oliver St. |

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G78829

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78829

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Meyers, Elmer Leroy

2. DATE OF DEATH: 10-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen Hosp

C. Length of stay in Baltimore: Yrs. / Mos. / Days: 16-05

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2402 W. Lanvale St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | June 3, 1892 | 57 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman (Rtd) | Jewelry | Balto., Md. | |

13. FATHER'S NAME: Harman Meyers

14. MOTHER'S MAIDEN NAME: Margaret Barline

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War #1 | 220-03-8570 | Mr. Charles Koob | 2402 W. Lanvale St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral embolism, rt — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Thyrotoxic heart disease c paroxysmal auricular fibrillation — at least 2 yrs

DUE TO

(C) Toxic nodular goitre — at least 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-1 1949 *to* 10-8 1949 *that I last saw the deceased alive on* 10-8 1949 *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marvin W. Davis M. D. | West Balto Gen Hosp | 10-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Twington for Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

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G78830

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 G78830 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HOWARD E GORSUCH

2. DATE OF DEATH OCTOBER 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1723 BENTALOU ST

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NONE 1723 Bentalou Street

c. Length of stay in Baltimore LIFE. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE BALTIMORE CITY
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE CITY.
D. STREET ADDRESS (If rural, give location) 1723 N BENTALOU STREET. 15-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Nov. 29, 1889 | 59 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Contractor | Contracting | Boring, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Mr. B. L. Freeny - 3 E. Lexington St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) APOPLEXY OCTOBER 7 | 1949. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) ARTERIOR SCLEROSIS | 1946. |
| | DUE TO (C) CHRONIC MYOCARDITIS.(FATTY) | 1946. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | HYPERTENSION | 1946. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| NONE | NONE | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NO | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* FEBY 3 1949, 19__, *to* OCT 8 1949, 19__, *that I last saw the deceased alive on* OCT 8 1949 *and that death occurred at* 5.A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H Slaughter M. D. | 3013 ST PAUL STREET | OCT 8 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/49 | Mt. Pleasant | Gamber, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

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G78831

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78831
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Dittell

2. DATE OF DEATH: 10-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1813 N. Smallwood St. zone 16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | June 23-1876 | 73 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CLERK | A & P STORE | Maryland | |

13. FATHER'S NAME: Ferdinand Dittell (D

14. MOTHER'S MAIDEN NAME: Margaret (D

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 207-14-5714 | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | |
| DUE TO | cardio | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerotic vascular disease | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Draining sinus of left chest wall | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-28- , 19 49 *to* 10-8- , 19 49 *that I last saw the deceased alive on* 10-8- , 19 49 *and that death occurred at* 10.20P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Rogers M. D. | Baltimore City Hospitals | 10-9-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/12/49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | M. Fahey & Sons 1827 W. North Ave. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Margarett Ellen Walker

2. DATE OF DEATH Oct. 8, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2601 E. Biddle St.

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2601 E. Biddle St.

3c. Length of stay in Baltimore Yrs. Life Mos. Days 8 - 03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Jan. 4, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Maryland | |

13. FATHER'S NAME William J. Harwood

14. MOTHER'S MAIDEN NAME Margarett A. Keith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | None | Vernon L. Dranbauer | 604 W. 34th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA - (PANCREAS) — INTERVAL BETWEEN ONSET AND DEATH: 8 MOS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8/26, 1949 *to* 10/8/, 1949 *that I last saw the deceased alive on* 10/8/, 1949, *and that death occurred at* 11.45 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. B. Moss M. D. | 448 N. Luzerne Ave | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12. 49 | Meadow Ridge Cemetery | Dorsey, Howard Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | William Cook Inc. | 1217 St. Paul St. |

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BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
43 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM C. DOLCH. 2. DATE OF DEATH Oct 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 727 W HAMBURG ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore LIFETIME. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD 21-31
d. STREET ADDRESS (If rural, give location) 727 W HAMBURG ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWER | APRIL 11-1875 | 74 | 5 / 30 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CRATE MAKER | GLOBE BREWERY | BALTIMORE MD. | |

13. FATHER'S NAME: NOT KNOWN
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-01-936
17. INFORMANT: BERSIE I. CARNEAL ADDRESS: 727 W HAMBURG ST

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocarditis | One |
| DUE TO | Hypertension + Generalized Arteriosclerosis | 15 yrs. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Feb 1st 1936 to Oct. 10, 1949 that I last saw the deceased alive on Oct 10, 1949. and that death occurred at 12:30 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hans Hate M. D. | 517 Scott St. | Oct 10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (If out of state) |
|---|---|---|---|
| BURIAL | Oct. 13-49 | HOLY CROSS CEM. | A A Co. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bernard C. Hess ADDRESS: 1216 E West St

VS 150

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CERTIFICATE CORRECTED 10-13-49

G788.34

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G788.34

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Frederick Priller

2. DATE OF DEATH October 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 428 Drew Street 2605

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH October 14, 1904
9. AGE (In years last birthday) 45 44
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Con Worker
10B. KIND OF BUSINESS OR INDUSTRY Continental

11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Clement Priller
14. MOTHER'S MAIDEN NAME Catherine FAISKEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Bertha Priller ADDRESS 428 Drew Street.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Hypertensive Cardiorenal Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 2, 1949, *to* October 9, 1949, *that I last saw the deceased alive on* October 9, 1949, *and that death occurred at* 10:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE John A. Spottel, Jr. M. D.
23B. ADDRESS Mercy Hosp.
23C. DATE SIGNED 10/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/13/49
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn
24D. LOCATION (City, town, or county) (State) Colgate Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 11 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Ulrich Funeral Home
ADDRESS 1901 Eastern Ave

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

394

Registered No. G788:5

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Geo W. Mowbray

2. DATE OF DEATH: Oct 7th 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 N Highland Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Md; b. COUNTY Balto; c. CITY, OR TOWN Balto; (If outside corporate limits, write RURAL and give township) 26-47

c. Length of stay in Baltimore: 40 yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1 N Highland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | 04 27 1870 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | | Md | Amer |

13. FATHER'S NAME: Luther Mowbray

14. MOTHER'S MAIDEN NAME: Julia Stewart

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Wilbur Mowbray | 1 N. Highland Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B) Chronic Nephritis — 7 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* January 20 1942 *to* Oct 7, 1949, *that I last saw the deceased alive on* Oct 6, 1949 *and that death occurred at* 4:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. V. Cleft M. D. | 5010 Greenleaf Road | 10-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/10/49 | Parkwood | Parkville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | Wilmot Funeral Home | 2095 Eastern Ave |

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G78836

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 v° 1

G78836 Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Max Cohen

2. DATE OF DEATH: 10-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 47 Yrs. ~~Mos.~~ Days

D. STREET ADDRESS (If rural, give location): Levindale 27-19

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | | 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser

10B. KIND OF BUSINESS OR INDUSTRY: Pants

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: L. Shulmeyer ADDRESS: 2043 Wilkens Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary sclerosis

DUE TO

(C) General Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 16, 1948, to 10-11, 1949, *that I last saw the deceased alive on* 10-10, 1949, *and that death occurred at* 5 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jerome J. Blumberg M. D.

23B. ADDRESS: Levindale Home

23C. DATE SIGNED: 10-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10-11-49

24C. NAME OF CEMETERY OR CREMATORY: United Hebrew

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949

REGISTRAR'S SIGNATURE: [illegible] for Baltimore, Md

25. FUNERAL DIRECTOR: Jack Reavis Inc ADDRESS: 2100 Eastern Ave

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G788.37

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 14

G788.37

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH SILBERBERG

2. DATE OF DEATH: 10-10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1834 Longwell Ave

C. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-19
D. STREET ADDRESS (If rural, give location): 1834 Longwell Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

13. FATHER'S NAME: Samuel

14. MOTHER'S MAIDEN NAME: Pearl

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Wolf Silberberg | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular - Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Uremia — 2 weeks

DUE TO

(C) Broncho-pneumonia — 36 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| none | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 7, 1949 *to* 10-10, 1949 *that I last saw the deceased alive on* 10-10-, 1949 *and that death occurred at* 12.30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. A. Ansoman M. D. | 1109 N. Calvert St | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-11-49 | United Hebrew | Oella Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | Jack Lewshe | 2100 Eutaw Pl |

VS 150

131a

G788.38

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G788.38

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Buckner

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2916 Rockrose Ave. 15-12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Good Will Ind.
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Hyman
14. MOTHER'S MAIDEN NAME: Esther Leah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Samuel Buckner ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arterio Sclerosis
(B) Diabetes Mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Bruce M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Oct. 10, 1949

24A. BURIAL, CREMATORY, REMOVAL (Specify): Burial
24B. DATE: 10-11-49
24C. NAME OF CEMETERY OR CREMATORY: Druid Israel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Reavis Inc ADDRESS 2100 Eutaw Pl

VS 151

61

G788:39

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G788:39

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James F. Frantz

2. DATE OF DEATH: 10/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4118 Hague Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4118 Hague Ave. 25-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | April 2, 1891 | 58 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | | Penna. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George E. Frantz | Margaret ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes Canadian Army World War #1 | 223-26-8631 | Mrs. Grace E. Frantz | 4118 Hague Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10/6/49

DUE TO

(B) Arteria - Sclerotic C.V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/27, 1948, *to* 10/5, 1949, *that I last saw the deceased alive on* 10/4, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jas. Lederer M.D. | 720 Outagamie Ave | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/11/49 | Balto. National Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: [illegible] SIGNATURE: [illegible] Washington Maryland, Md

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

937

G78840

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78840

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHANNE DOROTHY HOBELMANN
Hobelmann, Johanne Jose

2. DATE OF DEATH Oct. 9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Home for Incurables
700 W. 40th St.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY [redacted]
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore -18
D. STREET ADDRESS (If rural, give location) #1 W Bishop Rd. 12-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug 5-1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | none | Baltimore, Md. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Hobelmann Herman H. | Marmon, Marie |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | no | none | Laura Fiesher | 700 W. 40th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene right foot and 5 toes Lt. foot — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (B) Widespread arteriosclerosis of generalized type and Hypertensive Cardio-Vasc. Dis. — 20 years

DUE TO (C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 3rd, 1948, to Oct. 9th, 1949, *that I last saw the deceased alive on* Oct. 9th, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Conrad Wolff M. D. | 11 East Chase St. Baltimore 2 Maryland | 10/9/1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12, 49 | Baltimore Cemetery | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 11 1949 | Hunter for Williams, M.D. | Henry Sander & Sons Baltimore Md |

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93D

G788:1

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

120.0 G788:1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ARABELLE JONES

2. DATE OF DEATH Oct. 8. 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore -13
D. STREET ADDRESS (If rural, give location) 2042 N. Washington St.

3A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2042 N. Washington St.

3C. Length of stay in Baltimore Life (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Nov. 28. 1865 | 83 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10B. KIND OF BUSINESS OR INDUSTRY - - -
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel C. Horney
14. MOTHER'S MAIDEN NAME Margaret A. Wells
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs. Wm. H. Brown (sister) ADDRESS 2042 N. Washington St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of the right axilla — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
DUE TO
(B) Coronary Heart Disease
DUE TO
(C) Pulmonary Emphysema
Pernicious Anemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION July 11 - 1949
19B. MAJOR FINDINGS OF OPERATION Ca of the Axillary Glands
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 11, 1949 *to* 10-8-49, *that I last saw the deceased alive on* 10-8-49, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Fred Snyder M. D.
23B. ADDRESS 600 N. Eutaw Apts 11
23C. DATE SIGNED 10-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 11. 1949
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 11 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR HENRY SANDER & SONS. INC.
ADDRESS Baltimore Md.

VS 150

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678842

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1 5 9 678842 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERTHA MARIE JOHNSON

2. DATE OF DEATH: Oct. 8. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1902 E. Oliver St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: - -
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1902 E. Oliver St. 8-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 24. 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: - -

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Christian Kahl

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT / ADDRESS: Joseph Harrison - 1902 E. Oliver St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignancy of Gastro Intestinal Tract.

DUE TO

(B)

DUE TO

(C) Diabetes; Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1947, *to* Oct, 1949 *that I last saw the deceased alive on* 10-3, 1949, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Brennan M. D.

23B. ADDRESS: 5217 Harford Rd.

23C. DATE SIGNED: 10-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 11. 1949

24C. NAME OF CEMETERY OR CREMATORY: Moreland Mem. Park.

24D. LOCATION (City, Town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR / ADDRESS: HENRY SANDER & SONS. INC.

VS 150

Baltimore Md.

46M

G78843

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78843

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Schuman, Kenneth Loane

2. DATE OF DEATH: 10-10-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 407 Gittings Ave Balto 12

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 8-16-1898
9. AGE (In years last birthday): 51
If under 1 year: Months; Days
If under 24 hours: Hours; Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Fredrick Schuman
14. MOTHER'S MAIDEN NAME: Packie, Lillian

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patient ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | App. 2 days |
| DUE TO (B) | Pyonephrosis | Known 24 hrs |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Ureteral stricture | unknown |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Myocardial infarction, old | |

19A. DATE OF OPERATION: 9-17-49
19B. MAJOR FINDINGS OF OPERATION: Destroyed Lt. kidney + Lt. ureteral stricture
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* 9-17, 1949, *to* 10-10, 1949, *that I last saw the deceased alive on* 10-9, 1949, *and that death occurred at* 9:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: M. E. Cox M.D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 10-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 12/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Henry J. Enkins Sons
ADDRESS: 4908 York Rd

VS 150

133B

G78844

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | 51 | Registered No. G78844

1. NAME OF DECEASED (Type or Print): BARTOLOMEO BASSO

2. DATE OF DEATH: Oct. 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3706 Pennington Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3706 Pennington Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. 25-05
D. STREET ADDRESS (If rural, give location) 3706 Pennington Ave. Balto. Md.

c. Length of stay in Baltimore: 40 years (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | August 15, 1869 | 80 | 1 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Laboring Tailor | Italy | U.S.A. |

13. FATHER'S NAME: Frank Basso
14. MOTHER'S MAIDEN NAME: Anna Maggio

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Frank Basso | 2831 E. Biddle Street |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Stomach with Metastasis | 1 year |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-5 1949 *to* 10-8 1949 *that I last saw the deceased alive on* 10-7 1949 *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. J. Grinaldi M. D. | 4609 Gov. Ritchie Highway | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12. 49 | Holy Cross. A.A. | Arundel County |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | George J. Ruth Inc. | 1735 Harford Ave. |

VS 150

461

G78845 CERTIFICATE CORRECTED 10-14-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 8 16 1 G78845 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VICTORIA Grace / COOSENBERRY — 2. DATE OF DEATH: Oct. 8, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chase
D. STREET ADDRESS (If rural, give location): Eastern Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | May 30, 1949 1910 | 39 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Md. | |

13. FATHER'S NAME: Charles Reed
14. MOTHER'S MAIDEN NAME: Mary L. Griffin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mary L. Reed, Eastern Ave., Chase, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fracture of skull | |
| ANTECEDENT CAUSES | (B) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | public | Eastern Avenue near Earls Road |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10-8-49 2 a. m. | | Auto. & Truck Collision |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | 10-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 11/49 | [illegible] Cemetery | Eastern Ave Chase Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 11 1949 | [illegible] | Mrs Robert P Elliott & Daughter 1129 N. Caroline St |

VS 151

170c

G788:6

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E-812.4

Registered No. G788:6

1. NAME OF DECEASED (Type or Print) JAMES Matthew WASHINGTON N-8632

2. DATE OF DEATH October 10, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospital

3c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1111 N. Wolfe Street 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | Oct 19 12 | 37 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Henry Washington
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT Helena Washington ADDRESS 1111 Wolfe St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Generalized peritonitis | |
| | DUE TO rupture of jejunum | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| | DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | (C) Fracture of left tibia and fibula | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Bridge
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Back River Bridge, Essex, Maryland
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 8, 1949 5:40 P.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Russell S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 10-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 13/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24D. LOCATION (City, town, or county) (State) Q Q County Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Roberta A. Elliott & Daughter ADDRESS 1702 11292 N. Caroline St

VS 151

G788:47

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1949 G788:47 Registered No.

1. NAME OF DECEASED (Type or Print): ANNA CRABB

2. DATE OF DEATH: OCT. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: [redacted], Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2800 Northern Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | 2/5/1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Massachusetts | U. S. |

13. FATHER'S NAME: Erhardt Reithal

14. MOTHER'S MAIDEN NAME: Margaret Schopf

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | Husband | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinomatosis - Diffuse | 9 months |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Malnutrition | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 3/8/49 | Diffuse Carcinomatosis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. I hereby certify that I attended the deceased from 8/29, 1949 to 10/9, 1949 that I last saw the deceased alive on 10/9, 1949, and that death occurred at 4:40 P. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Amsterdam M.D. | Franklin Square Hosp. | 10/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 10/12/49 | Parkwood | Taylor Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams M.D. | Mildred T. Blight | 6009 Harford Rd. |

VS 150

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6788:8

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 6788:8

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RICHARD POMPHREY

2. DATE OF DEATH: OCTOBER 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SYDENHAM HOSPITAL

c. Length of stay in Baltimore: 12 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: ANNE ARUNDEL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GLEN BURNIE
D. STREET ADDRESS (If rural, give location): 8th AVENUE NORTH

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | JUNE 25, 1928 | 21 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MACHINIST | | GLEN BURNIE, MARYLAND | USA |

13. FATHER'S NAME: EDWARD POMPHREY

14. MOTHER'S MAIDEN NAME: MARGARIET KRAUSE

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 215-24-7480 | WIFE | 8th Ave. North, Glen Burnie, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
(A) Cardiorespiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
(B) Paralytic poliomyelitis — 14 Days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* SEPT 27, 1949 *to* OCT 8, 1949 *that I last saw the deceased alive on* Oct 8, 1949, *and that death occurred at* 11 25 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lakman B. Young M.D. | Sydenham Hospital | Oct 8 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/12/49 | GLEN HAVEN | PITCHIE HIGHWAY |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | JOHN F. DENNY, JR. | 715 LIGHT ST BALTO.-30, MD |

26

G78849

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78849

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Julia H. Housenan

2. DATE OF DEATH Oct. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3800 Bank St.

c. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3800 Bank St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | widowed | Dec 28 1873 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | None | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME Conrad Alwather

14. MOTHER'S MAIDEN NAME Susan Powell

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Mrs Mina Bewig | 258 Chester |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)

(A) Carcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH 18 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July, 1948 *to* Oct 10, 1949, *that I last saw the deceased alive on* Oct 9, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo S Lippy M. D. | 432 N Patterson Park Ave | 10/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 13 1949 | Baltimore Cem. | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT | Registrar Baltimore, Md | John A. Moran | 3000 E Balto Balto 24, Md |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Franklin P. Reigle

2. DATE OF DEATH 10/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Lansdowne
D. STREET ADDRESS (If rural, give location) 2349 Monumental Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 7-15-1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | — | Maryland | U.S.A. |

13. FATHER'S NAME William T. Reigle

14. MOTHER'S MAIDEN NAME Frances C. Shaw

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | None | Gertrude Reigle 2349 Monumental Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE CEREBRAL HEMORRHAGE - LEFT

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CARDIO-VASCULAR DISEASE

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/6, 1949 *to* 10/8, 1949 *that I last saw the deceased alive on* 10/8, 1949, *and that death occurred at* 11:05 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Shaw M. D. | St. Agnes Hosp. | 10/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12, 1949 | Meadowridge Cem. | Dorsey Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Cunningham Williamsville, Md. | Joseph T. Cumbrune | 1328 Lafayette Ave. |

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937

G78851

BIRTH NO. G78851

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN H. HESMAR

2. DATE OF DEATH: Oct. 8 - 1949

3. PLACE OF DEATH: Baltimore City, Maryland 237 S. CALHOUN ST

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 237 S. CALHOUN ST. 19 03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | AUG. 12 - 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| TAILOR | DEPT. STORE | BALTIMORE MD. | U.S.A. |

13. FATHER'S NAME: MARTIN HESMAR

14. MOTHER'S MAIDEN NAME: GERTRUDE DIETRICH

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | 212-01-3592 | Mary A. Hesmar | 237 S. Calhoun St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Cerebral Hemorrhage | 3 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April 1949 *to* Oct 1949 *that I last saw the deceased alive on* 10/9 1949 *and that death occurred at* 2:00 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. A. Tulbierski M. D. | 1947 W Baltimore St | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12 - 1949 | Holy Cross Cemetery | A.A.CO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams M.D. | Elizabeth Hacke Inc. | 115 S. West St. |

VS 150

93D

G78852

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78852

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Greg Brown

2. DATE OF DEATH: Oct 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 942 N. Wolfe St

c. Length of stay in Baltimore: 3 5 70 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 942 N. Wolfe St 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C. | Widow | June 11, 1891 | 58 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Clifton Brown ADDRESS: 1027 N. Dunbar St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardio - renal disease. — 11 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* August, 1938 *to* October 8 1949, *that I last saw the deceased alive on* Oct. 8, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harold B. Luke M.D. | 1501 E. Eager Street | 10/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Arbutus M. Park | Arbutus Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Mitchell M.D. | Mrs Wheeler Elliott & Daughter | 1312 1129 N. Carrollton Ave |

VS 150

Del. at Med. Exams Case. Not to Med. Exams Case
Released to Hosp.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 678853

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arthur Everest
2. DATE OF DEATH: Oct 8, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 4-04
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Co.
D. STREET ADDRESS (If rural, give location): 2026 Cambridge St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: William Everest
14. MOTHER'S MAIDEN NAME: Eleanor ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Myocardial Infarction | 1 hr |
| DUE TO | | |
| (B) | Coronary Occlusion | 1 hr |
| DUE TO | | |
| (C) | Arteriosclerosis of Coronary Arteries | yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-8-, 1949 *to* 10-8-, 1949 *that I last saw the deceased alive on* 10-8-, 1949 *and that death occurred at* 8 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Lukens M. D. | JOHNS HOPKINS HOSPITAL | 10-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/12/49 | Mt. Olivet | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | Lilly & Zeiler Inc. | Balto. |

VS 150

942

G78854

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78854

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES L. (Warmick) Or James L. Wormick — N-803.2 — 2. DATE OF DEATH: Oct. 7. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Co.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: 13 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River
D. STREET ADDRESS (If rural, give location): 619 Wampler Rd. Middle River, Md. 20

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | June 26. 1913 | 36 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Construction | Tenn. | U.S.A. |

13. FATHER'S NAME: William E. Wormack

14. MOTHER'S MAIDEN NAME: Byrdie Wormack

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Gladys Wormack — ADDRESS: 619 Wampler Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Eastern Avenue near Earls Rd.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 8. 1949 Approx. 2a. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Auto. & Truck collision

22. *I certify that I took charge of the remains described above, held an* Autopsy (partial) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Carl L. Kaye M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 10-8-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 12. 49 | St Stevens | Balto. Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Elroy O. Wilson 1000 Brantly Ave.

VS 151

170C

G78855

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78855

BIRTH NO. 49-2[illegible]

1. NAME OF DECEASED (Type or Print): Baby Boy Sponsel

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 4634 Northwood Dr

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | | 10/10/49 | | | 1 | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Sponsel | Dorothy Whlfelder |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis — DUE TO

ANTECEDENT CAUSES

(B) Anemia — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Premature separation of placenta of mother

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/10 *to* 10/10 *, 19*49*, that I last saw the deceased alive on* _____ *, 19*__*, and that death occurred at* 9 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Andrews M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/12/49 | Oakleaven | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Timothy Williams, M.D. | Leonard J. Rusk | 305 Hopkins Pl |

VS 150

161a

Dr. Breman. ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 78856 0 23 Registered No. G78856

1. NAME OF DECEASED (Type or Print): Frank Joseph Lanasa

2. DATE OF DEATH: Oct 10-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2806 Echodale Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 2806 Echodale Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | Married | June 13-1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired SALESMAN | WHOL. FRUIT | Italy | ✓ |

13. FATHER'S NAME: Michael Lanasa

14. MOTHER'S MAIDEN NAME: Anna

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Marie Lanasa-2806 Echodale |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Cardiovascular Lues

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July, 1945 *to* Oct, 1949 *that I last saw the deceased alive on* Oct 9, 1949 *and that death occurred at* 4A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas J Breman M. D. | 5217 Harford Rd | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Thurlington Williams, M.D. | Leonard J Luck | 5305 Harford. |

VS 150

20E

G78857

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

81

Registered No. G78857

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry L. McCoy

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3441 Edmondson Avenue
C. Length of stay in Baltimore: 58 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3441 Edmondson Avenue 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 26, 1891 | 58 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John L. McCoy
14. MOTHER'S MAIDEN NAME: Lily Scharf
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mary T. McCoy ADDRESS: 3441 Edmondson Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma Of The Bladder | 6 mos + |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1 1949 *to* 10/9 1949 *that I last saw the deceased alive on* 10/9 1949 *and that death occurred at* 7½ *m., from the causes and on the date stated above.*

23A. SIGNATURE: T. E. Roach M. D.
23B. ADDRESS: 3629 Edmondson Ave - 29
23C. DATE SIGNED: 10/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/12/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. Meeks and Son ADDRESS: 803 N. Calvert St.

VS 150

T. E. Roach

528

G78858

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78858

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary J. Lyon

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Northwood Apartments Lochraven Boulevard

c. Length of stay in Baltimore: 71 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Lochraven Boulevard 27-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 14, 1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | ------- | Baltimore, Md. | |

13. FATHER'S NAME: John Ball

14. MOTHER'S MAIDEN NAME: Catherine Carr

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Robert M. Lyon | 1303 Crofton - ced |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10 - 9. 49 7 3 p.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-7-49 *to* 10-9-49, *that I last saw the deceased alive on* 10-9-49, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert E. Lyon M. D. | 2330 E Balt | 10 10 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | H. W. Meats & Son | 505 N. Calvert St. |

VS 150

94a

Dr. Muse
5 W. 29 Th St.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

41 Registered No. 678859

STATE FILE NO. 678859

1. NAME OF DECEASED (Type or Print): Charlotte Mary Dietz
2. DATE OF DEATH: Oct. 9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1704 Gorsuch Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1704 Gorsuch Ave. ? - 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | widowed | Mar. 9-1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Baltimore Md. | |

13. FATHER'S NAME: Lorenz Richter
14. MOTHER'S MAIDEN NAME: Charlotte Seebach

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Philip Dietz | 1704 Elmbank |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Malignant hypertensive Cardiovascular | |
| DUE TO | disease. Cerebral hemorrhage | |
| | acute, massive. | 7 Oct '49 |
| (B) DUE TO | | |
| (C) | Generalized Arteriosclerosis | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 26 July, 1946 *to* 9 Oct., 1949, *that I last saw the deceased alive on* 9 Oct, 1949, *and that death occurred at* 10.05 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph E. Muse Jr. M.D. | 5 West 29th St. | 10 Oct '49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-12-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5305 Harford. |

VS 150

G78860

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78860

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Annie Dougherty

2. DATE OF DEATH Oct. 8-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 1832 W. Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1832 W. Baltimore

c. Length of stay in Baltimore 84 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Nov. 14-1864 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | Housework | Maryland | U.S. |

13. FATHER'S NAME Thomas Dougherty

14. MOTHER'S MAIDEN NAME Annie Shiel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Gladys Dougherty | 1903 N. Santeo St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | 1938 |
| DUE TO (B) | Rheumatoid Arthritis | 1938 |
| DUE TO (C) | Arteriosclerosis | 1938 |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 5 1949 *to* Oct. 8, 1949 *that I last saw the deceased alive on* Oct. 8 1949 *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Brown M. D. | 1663 W. Mont St | 10/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-49 | Cocksdale | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | [illegible] | Geo. A. Farley | Baltimore & Fayette Sts. |

VS 150

93c

G78861 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78861 Registered No.

1. NAME OF DECEASED (Type or Print): August C LESMAN

2. DATE OF DEATH: 10-9-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, MARYLAND.
D. STREET ADDRESS (If rural, give location): 1210 Monterey Avenue 25-43

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated
8. DATE OF BIRTH: 4-16-1888
9. AGE (In years last birthday): 60 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENGINEER
10B. KIND OF BUSINESS OR INDUSTRY: STATIONARY ENG.
11. BIRTHPLACE (State or foreign country): GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Lesman
14. MOTHER'S MAIDEN NAME: Lena —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-03-5142
17. INFORMANT: Mrs. Mary C. Lesman ADDRESS: 1210 Monterey Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock — INTERVAL BETWEEN ONSET AND DEATH: 30 hours
DUE TO
(B) Acute Myocardial failure — 72 hours
DUE TO
(C) Arteriosclerotic heart disease — years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cirrhosis of liver; ascites

19A. DATE OF OPERATION: 10/7/49
19B. MAJOR FINDINGS OF OPERATION: Ascites; Cirrhosis of liver

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/7/49 to 10/9/49, that I last saw the deceased alive on 10/9/49, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Fred Hawkins Jr. M. D.
23B. ADDRESS: Franklin Square Hosp.
23C. DATE SIGNED: 10/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-13-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, Town, or County) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: OCT 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Farley ADDRESS: Fallsway cor. Fayette St.

VS 150

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G78862

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

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G78862

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) MSGR. LOUIS O'DONOVAN | 2. DATE OF DEATH Oct. 9, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital<br>c. Length of stay in Baltimore Yrs. Mos. Days | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore<br>D. STREET ADDRESS (If rural, give location) 31 N. Fulton Ave. 19-07 |

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 1877 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PRIEST | RELIGIOUS | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles O'Donovan | Henrietta Hyatt Jenkins |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes. | | None | Rt. Rev. Mgr. O'Donovan | " |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion.

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease.

DUE TO

(C) Acute Urinary Infection.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* October, 1949, *to* October 9, 1949, *that I last saw the deceased alive on* October 9, 1949, *and that death occurred at* 11.20 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. J. Castellano M. D. | Bon Secours Hospital | 10.9.49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-12-49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | George A. Farley | Fulton Ave & Fayette St. |

VS 150

93D

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G788[illegible]3

BIRTH NO. [illegible]

1. NAME OF DECEASED (Type or Print): Johan Hill

2. DATE OF DEATH: Sept 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Med. Cases

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: [illegible]
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): North Point Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | W | 7-4-83 | 56 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Virginia | |

13. FATHER'S NAME: Frank Hill

14. MOTHER'S MAIDEN NAME: Maggie ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Hypertensive cardio vascular disease —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO: Massive gastro intestinal hemorrhage, site unknown

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-28-, 19[illegible]9 *to* 9-28-, 19[illegible]9, *that I last saw the deceased alive on* 9-28-, 19[illegible]9 *and that death occurred at* 3:20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Blythe H. Schroeder M. D. | JOHNS HOPKINS HOSPITAL | 9/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | OCT 11 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | Commissioner of Health |

VS 150

[illegible] 937

G78864 X ✓ G78864

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 33 Y

Registered No.

STATE FILE NO.

1. NAME OF DECEASED (Type or Print) Wm. C Talbott William C. Talbott

2. DATE OF DEATH 10-10-49

3. PLACE OF DEATH: a. Baltimore City, Maryland Univ. Hosp.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pikesville
D. STREET ADDRESS (If rural, give location) 4234 Milford Mill Road

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Nov. 4, 1881 | 67 yrs | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Spec. Police | Officer-Balto Natl Bk | Calvert County, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John S. Talbott | Elizabeth Mattingly |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 216-14-1307 | Mr. W. Charlton Talbott, | 4234 Milford Mill Rd Pikesville 8, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6-10 hrs.

DUE TO (B) Generalized Arteriolosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-9 1949, *to* 10-10 1949, *that I last saw the deceased alive on* 10-10 1949, *and that death occurred at* 12 noon, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. M. Smith Jr. M. D. | Univ. Hosp. | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 13, 1949 | Loudon Park Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 11 1949 | Huntington Williams, M.D. | Wallis Lamoreau | 4510 Liberty Hgts Avenue |

VS 150

82B

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4th

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Harvey S. Wirtz

2. DATE OF DEATH: 10-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 413 Virginia Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | 12-4-1873 | 75 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Radio

10B. KIND OF BUSINESS OR INDUSTRY: Block & Parker

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Elizabeth Walken

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Patient ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 20 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) generalized arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10-11-47

19B. MAJOR FINDINGS OF OPERATION: large Rt. inguinal hernia

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9-49, 19__, *to* 10-12-49, 19__, *that I last saw the deceased alive on* 10-12, 1949, *and that death occurred at* 3 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Cotz M. D.

23B. ADDRESS: Union Memorial Hospital

23C. DATE SIGNED: 10-12-49

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify)

24B. DATE: 10/14/49

24C. NAME OF CEMETERY OR ~~CREMATORY~~: New Freedom

24D. LOCATION (City, town, or county) (State): New Freedom, Penna.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. Frank Stonesifer ADDRESS:

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78856 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nicholas Hartman

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 23 S. Stricker St. 19-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | White | Divorced | 6/1/1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mill Wright | Hospital | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Michael Hartman | Christina Booze |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | ? | Pauline Engel | 153 Poplar Grove St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| John R Davis, M.D. | | Oct. 10, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/12/49 | Mt Olivet Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Thurlington Williams, M.D. | Pott C & B M Walker | Proof Stricker St |

VS 151

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 490

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (Frank A. McConville) Francis A. McConville (correct) — 2. DATE OF DEATH: Oct. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 26 S. Schroeder St. 18 03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | DIVORCED | 9/15/1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PRODUCE DEALER | MARKET | BALTO MD | |

13. FATHER'S NAME: Joseph B. McConville
14. MOTHER'S MAIDEN NAME: DELIA TIDE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | NONE | Donald C. McConville | 1507 E. Preston St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia, rt. upper lobe

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic alcoholism

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Russell S. Fraher, M.D. | | Oct. 11, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/12/49 | NEW CATHEDRAL | BALTIMORE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1949 | Huntington Williams, M.D. | Pott & B. M. Walters | Pikesville Stockbridge |

VS 151

108

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillie Wallis 560-5

2. DATE OF DEATH: 10/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1728 N. Broadway
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 1728 N. Broadway 8-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months / Days | If Under 24 Hours Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | July 27 1865 | 84 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hanford Co Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob E Bull
14. MOTHER'S MAIDEN NAME: Mary E Sundyland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Enterocolitis & Intestinal Perforation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. J. Turbeville M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 10/10/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | Rock Spring | Forest Hill, Harford Co Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Fulton & Doe

VS 151

122a

G78869

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78869 Registered No. 171

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Daisy LeCompte

2. DATE OF DEATH: Oct 9 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1439 W Franklin St

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1439 W Franklin St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | July 10, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | St Michaels Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| unknown | Hannah Bowling |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Carl Johnson | 1439 W Franklin St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomas of Uterus fundii — INTERVAL BETWEEN ONSET AND DEATH: 6 Mos
DUE TO and Metastasis to intestinal tract
(B) Fibroid uterus — 15 yrs.
DUE TO
(C) None

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
none

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 1949 | generalized Carcinoma of abd intestinal tract & Liver | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* May 1949, *to* Oct 9 1949, *that I last saw the deceased alive on* Oct 9 1949, *and that death occurred at* 7:30 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph J Young M. D. | 1429 E Monument St | 10/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 12/49 | Mt Calvary Cem | B. C. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/11/49 | Huntington Williams, M.D. | Mrs Robert E. Ellicott / Daughter | 48 B 1129 N. Caroline St |

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G78870 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter Kirkwood

2. DATE OF DEATH: OCT 9 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Florida
B. COUNTY
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Miami Beach
D. STREET ADDRESS (If rural, give location): 849 West ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10-27-94
9. AGE (In years last birthday): 54 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Matthew Kirkwood
14. MOTHER'S MAIDEN NAME: Isabel London

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarct — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary thrombosis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Obesity

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-5-, 1949 *to* 10-9, 1949, *that I last saw the deceased alive on* 10-9, 1949 *and that death occurred at* 4:35 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph D. B. King, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: 10/14/49
24C. NAME OF CEMETERY OR CREMATORY: Bellefountaine
24D. LOCATION (City, town, or county) (State): St Louis Missouri

DATE RECEIVED BY REGISTRAR: OCT 12 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Chas C. Towell — ADDRESS: 3427 Edmondson Ave

94a

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 401

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Hilda Stokes

2. DATE OF DEATH: 10-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural- Baltimore County
D. STREET ADDRESS (If rural, give location): 308 Sollers Point Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | COL | SINGLE | March 17-1939 | 10 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: None.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: McCray Stokes

14. MOTHER'S MAIDEN NAME: Ruth Fowlkes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease with active myocarditis and endocarditis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22- , 1949, *to* 10-9- , 1949, *that I last saw the deceased alive on* 10-9- , 1949, *and that death occurred at* 7.30 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: W. S. Logen Jr M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-12-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem
24D. LOCATION (City, town, or county) (State): B. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 9
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: H. Rayner Sanders
ADDRESS: 92 c 1412 E Preston St

VS 150

G 8872 ✓ G788872

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 4309 Registered No.

1. NAME OF DECEASED (Type or Print): Anna Boston Rice

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 Druid Hill Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1604 Druid Hill Ave. 14-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widow | Aug. 1, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Presser | Laundry | Maryland | U. S. A. |

13. FATHER'S NAME: Richard Boston

14. MOTHER'S MAIDEN NAME: Melvina Broom

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT / ADDRESS: Mrs. Cornelia McNeil 1604 Druid Hill

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Cut-Gunshot Bacteriemia
DUE TO Cyanosis
(b) Local Infection
DUE TO Hypostasis - R.
Extremities Gangrenous

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Several Weeks

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office building, etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 7/16/49 to 10/10/49, that I last saw the deceased alive on 10/9/49, and that death occurred at 4 P.M. from the causes stated on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. L. Barksdale, M.D. | 526 N. Dover St | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 10-13-1949 | Arbutus Mem. Park | Baltimore Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 12 1949

REGISTRAR'S SIGNATURE: Courtenay Williams, M.D.

25. FUNERAL DIRECTOR / ADDRESS: Jesse W. Bodden 436 W. Biddle

VS 150

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): PETER LEO MURPHY

2. DATE OF DEATH: Oct. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2811 Cheswolde Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2811 Cheswolde Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | Aug. 31, 1888 | 61 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Retail Dept. Store | Nyack, N. Y. | |

13. FATHER'S NAME: Murphy

14. MOTHER'S MAIDEN NAME: Catherine

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| no | | |

17. INFORMANT: Mrs. H. F. Grieneisen — ADDRESS: 2811 Cheswolde Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 day |
| DUE TO (B) | Arteriosclerotic Heart Disease | 10 yrs. |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1, 1949, *to* October 11, 1949, *that I last saw the deceased alive on* Oct 11, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton E Lawman M. D. | 4843 Park Heights Ave | 10/12/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | Lorraine Cem. | Woodlawn Cem. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 1 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92D

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G788'74

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

80 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY LEE RAYFIELD

2. DATE OF DEATH: Oct 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 713 E. 20th St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 713 E. 20th St. 9 0 8

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Dec. 7, 1891 | 57 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Freight Conductor | Railroad | Baltimore, Md. | |

13. FATHER'S NAME: Charles H. Rayfield

14. MOTHER'S MAIDEN NAME: Emma S. Allison

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Mrs. Annie M. Rayfield | 713 E. 20th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Adeno-Carcinoma of left Kidney | Oct 1949 |
| DUE TO (B) | Generalized Metastasis to Skin, ribs, axillary | 2 Month |
| DUE TO (C) | Lymph nodes | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 30/49 | Carcinoma of Left Kidney - Removed | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1949, to Oct 10, 1949, *that I last saw the deceased alive on* Oct 9, 1949, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gilman R. Dwight M. D. | 10 E. Biddle St | Oct 11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | Glen Haven Cem. | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 19 | Lauriston Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

52a

G788'75 ✓ G788'75

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print): Raymond E. Hamilton

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 Mc Eldery Court (emw) 5-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Single | Dec. 17, 1938 | 10 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | | Balto., Md. | |

13. FATHER'S NAME: Edward Hamilton

14. MOTHER'S MAIDEN NAME: Cecelia Willis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Edward Hamilton, | 436 N. Eden St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage (Spontaneous)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Oct. 10, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | Mt. Auburn | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Huntington Williams, M.D. | Robert L. Young | 532 E. Monument St. |

VS 151

83a

G78876

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78876 Registered No. 331

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Matthews Smith

2. DATE OF DEATH: 10/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 25Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 901 Bennett Place 16 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 4/15/1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Self Employed | Huskster | North Carolina | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Sarah Smith-901 Bennett Place |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO

(B) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-8, 1949, *to* 10-11, 1949, *that I last saw the deceased alive on* ____ 19____ *and that death occurred at* 4-A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles T. Mackall, M. D. | 861 Hanlon Pky | 9-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/14/49 | Mt. Auburn Ct. | Baltimore City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | | J. L. Brown & Son | 108 W. Montgomery St |

VS 150

83a

G 8877 ✓ G78877

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Paula M. Matthews 77-5

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 430 W. Henrietta St. 22-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | Single | 6/3/49 | | 4 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: William Matthews

14. MOTHER'S MAIDEN NAME: Jessie Mae Aytich

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|---|
| | | | William Matthews, 430 W. Henrietta St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malnutrition
DUE TO
Prematurity
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Oct. 10, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/12/49 | Mt Calvary | A. A. Co, Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 12 1949
REGISTRAR'S SIGNATURE: (Deputy) for Williams, M.D.
25. FUNERAL DIRECTOR: J. L. Brown & Son - Montgomery St ADDRESS: 1012 W

VS 151

159 ✓

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MATHILDA Tilly HIND

2. DATE OF DEATH 10-11-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2904 Reistertown Road
C. Length of stay in Baltimore 23 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-05
D. STREET ADDRESS (If rural, give location) 2904 Reistertown Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | | 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Benjamin Lollmann
14. MOTHER'S MAIDEN NAME Hettchen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Nathan Lund ADDRESS 2904 Reist Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Abdominal Carcinomatosis
DUE TO Causing intestinal obstruction & Bile duct obstruction
(B)
DUE TO none
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 9/16/49
19B. MAJOR FINDINGS OF OPERATION Carcinoma throughout abdomen
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 1, 1949 to Oct. 11, 1949 *that I last saw the deceased alive on* 10/11, 1949, *and that death occurred at* 6 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Theodore Cooper M. D.
23B. ADDRESS 2701 Eutaw Place
23C. DATE SIGNED 10/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-12-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 12 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

VS 150

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G78879 G78879

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH COHEN

2. DATE OF DEATH: 10-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2528 Quantico Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13

c. Length of stay in Baltimore: 41 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2528 Quantico Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | Store | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Isaac | Ida |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Ethel Cohen | 2528 Quantico Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

(B) acute coronary thrombosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/20 19 49 *to* 10/11 19 49 *that I last saw the deceased alive on* 10/11 19 49, *and that death occurred at* 12:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. C. Fabian M. D. | 1454 E Balt St | 10/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Huntington Williams M.D. | Jack Lewis Inc | 2100 Eastern Ave |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hyman A. Rosen
2. DATE OF DEATH: 10/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): md Genl Hosp
c. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md 36 20 5th
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2620 Shirley avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Jewish WHITE | married | 8-20-1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | self | Russia | |

13. FATHER'S NAME: Abraham
14. MOTHER'S MAIDEN NAME: Not known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mary Rosen | 2620 Shirley Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerotic Heart Disease?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-11 1949 *to* 10-12, 1949 *that I last saw the deceased alive on* 10-12, 1949 *and that death occurred at* 3 05 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Caroll | md. Genl Hos | 10-12 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-12-49 | Hebrew Mt Carmel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Thurlington Williams M.D. | Jack Lewis & Co | 2100 Eutaw Pl |

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93D

Hospital. Deceased

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

716 G78831 Registered No.

BIRTH NO. 23-49-2168

1. NAME OF DECEASED (Type or Print): Baby Girl Gladney

2. DATE OF DEATH: Oct. 6/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland (JOHNS HOPKINS HOSPITAL)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 5-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 421 N. Eden St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | NB Baby | 10-5-49 | | 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: John Gladney

14. MOTHER'S MAIDEN NAME: Mamie Landers

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death) (A) | Prematurity | 2 d. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-5- 1949 *to* 10-5- 1949, *that I last saw the deceased alive on* 10-6, 1949 *and that death occurred at* 7:50 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leon Rosenstein M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Hoy Funeral | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | | |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose C. Freeman

2. DATE OF DEATH: 10/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md. Gen Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. General Hospital
C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 907 Cathedral St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | widow | Sept 5, 1873 Oct 10 1949 | 76 | 1 | 5 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Balto. Md. | U.S. |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Mary Jane Kelly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Edna C. Brunsdack | 5 Hillcrest Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — (INTERVAL BETWEEN ONSET AND DEATH) ?

DUE TO

(B) Hypertensive cardiovascular — ?

DUE TO

(C) Arteriosclerotic cardiovascular disease — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic passive congestion — ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8/6, 1949, *to* 10-10, 1949 *that I last saw the deceased alive on* 10-10, 1949 *and that death occurred at* 1.05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Candler M. D. | Md gen Hosp | 10/10 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Oct 12/49 | Greenmount Cem. | Baltimore Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: 10/13/49 — REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: John D. Mitchell Sons — ADDRESS: 1900 Eutaw Place

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G78883 ✓ 443 G78883

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G 78883

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMMA FLORENCE MARSHALL

2. DATE OF DEATH: OCTOBER 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home, 6000 Bellona Avenue

C. Length of stay in Baltimore: 32 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-25
D. STREET ADDRESS (If rural, give location): 3034 Fleetwood Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Jan. 11, 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | Home | Maryland | |

13. FATHER'S NAME: William Shoemake

14. MOTHER'S MAIDEN NAME: Elizabeth Carroll

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Carroll Marshall ADDRESS: 3034 Fleetwood Ave. Balto.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebro vascular hemorrhage | 6 weeks. |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive cardio vascular disease | ? |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 5, 1949, *to* October 10, 1949, *that I last saw the deceased alive on* Oct. 10, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. W. Thomas M. D. | Towson, Md | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10.13.1949 | Springfield | Sykesville, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10/12/49 | Huntington Williams, M.D. | C. Harry Weer, | Sykesville, Maryland |

VS 150

93-D.

G78884 G78884

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 443

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): William Franklin Carter
2. DATE OF DEATH: 10/9/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital, Balto. Md.
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-31
D. STREET ADDRESS (If rural, give location): 900 Bennett Place, Balto. Md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | single | Apr. 17, 1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| utilityman | Seaman | Maryland | U.S. |

13. FATHER'S NAME: William Carter
14. MOTHER'S MAIDEN NAME: Ellen Todd

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| unknown | unknown | Records, U.S. Marine Hospital, Balto. Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hydrothorax, right, with atelectasis right lung and pulmonary edema. Pneumonia, left lower lobe. — Interval between onset and death: 3 days

DUE TO

(B) Post-operative state, right. Thoraco-lumbar sympathectomy — 7 Days

DUE TO

(C) Hypertension cardiovascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Cardiac hypertrophy
Hematoma, retro-pleural, paravertebral, bilateral — unknown

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/9/49 and 10/3/49 | done for relief of hypertension. Hemstone was post operation | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* August 11, 1949 *to* October 9 1949, *that I last saw the deceased alive on* October 9 1949, *and that death occurred at* 4:15 pm *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director, Clinical Director — John L. Wilson | U.S. Marine Hospital, Balto. | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-1949 | Mt. Auburn Cem | Balto. Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 12 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Mrs Katie R. Williams — ADDRESS 3224 Edmondson Ave

VS 150

93D

G78885

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78885 Registered No.

BIRTH NO. Minnie

1. NAME OF DECEASED (Type or Print) Minnie Powell

2 DATE OF DEATH Oct. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto.
D STREET ADDRESS (If rural, give location) 1419 Myrtle Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1419 Myrtle Ave.

c. Length of stay in Baltimore 2 Mos. Days

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | June 10, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Halifax Co. Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Peter Irby | Sallie Brown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Rosenelt Irby | 1419 Myrtle Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage 6 hours

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B)

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 1, 1949, to Oct 4, 19__, *that I last saw the deceased alive on* Oct 8, 1949, *and that death occurred at* 5.30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William H. Watts M.D. | 515 Lexington | 10/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-12-1949 | Halifax Co. Va | Halifax Co. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Countersigned for Milton [illegible] | Mrs Katie R. Williams | 3224 Edmondson Ave |

VS 150

93D

G78886

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78886 Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): ASA HURTT | 2. DATE OF DEATH: 10-9-49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission): A. STATE: Maryland. B. COUNTY: None. |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore |
| c. Length of stay in Baltimore: Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location): 613 Bradley St. 17 01 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro. | Married. | May 18, | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Virginia. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Hurtt | Irene Oliver |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Freddie Hurtt | 613 Bradley St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatic Cirrhosis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-27 1949 *to* 10-9 1949, *that I last saw the deceased alive on* 10-9, 1949, *and that death occurred at* 4:40 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Patterson Mack M. D. | University Hospital | 10-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-49 | W. P. Auburn Cem | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Thurlington Williams, M.D. | Mrs Katie R. Williams | 322 N. Schroeder St |

VS 150

1248

G78887 ✓ G78887

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 171

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kate Washington

2. DATE OF DEATH: 10.9.49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1317 MadisonAve

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Ave

c. Length of stay in Baltimore: Yrs. _____ Mon. _____ Days _____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-24
D. STREET ADDRESS (If rural, give location) 1317 Madison Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col. | Widow | Jan. 1 1883 | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Northumberland Co. Va. | U. S. A. |

13. FATHER'S NAME: Lewis Starkis

14. MOTHER'S MAIDEN NAME: Martha Locust

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Beatrice Cannon | 1217 N. Stricker St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | uremia | 4 days |
| DUE TO (B) | metastatic carcinoma | not known |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | carcinoma uterus | not known |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Spastic Paralysis both legs<br>large nodular uterine fibroid | not known |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8.17.49 19__, *to* 10.9.49 19__, *that I last saw the deceased alive on* 10.8.49 19__, *and that death occurred at* 9a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James M. Pair M. D. | 400 N. Carrollton ave | 10.9.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10-12-49 | Mt. Auburn Cem. | Balto | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 3224 Schroeder St. |

VS 150

48B

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

G78888 Registered No.

BIRTH NO. G [illegible] Rosanna

1. NAME OF DECEASED (Type or Print): Rosanna A. VanNess

2. DATE OF DEATH: Oct 10-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 813 Abbott Court
C. Length of stay in Baltimore: Yrs. [ ] Mos. [ ] Days [ ]

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 813 Abbott Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Sept 28. 1868 | 81 | 0 | 12 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | Home Work | Orange N. J. | U.S.A. |

13. FATHER'S NAME: John Wesley Talbert

14. MOTHER'S MAIDEN NAME: Genevave Wolf

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | ? | Mrs Edith McClary | 813 Abbott Ct. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cerebral Hemorrhage

DUE TO

(B) Hypertension & Arteriosclerosis

DUE TO

(C) Fracture 4th Lumbar Spine

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | home | 813 Abbott Ct |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10 / 1 / 49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | Fell getting Hemorrhage |

22. *I hereby certify that I attended the deceased from* 10/1, 1949 *to* 10/9, 1949, *that I last saw the deceased alive on* 10/9, 1949, *and that death occurred at* 7:15 *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. J. Homatem M. D. | 3044 E. Lodge St | 10/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-49 | Moreland Memorial Pk | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Huntington Nitkiewicz, M.D. | Elmer W. Conklin | 824 E. Eager St |

VS 150

832a

BIRTH NO. 678889

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 678889

1. NAME OF DECEASED (Type or Print): Helen Marguret McCleary
2. DATE OF DEATH: 10-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. gen'l Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore County
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 206 Wicklow Road Ferndale

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M. | 8-21-1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife - | Home. | Balto. | |

13. FATHER'S NAME: William H. Blair
14. MOTHER'S MAIDEN NAME: Margaret D. Kersey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Family | Home. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hepato-renal failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(B) & jaundice
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Extensive carcinomatosis of liver — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Acute cardio respiratory collapse 10-9-49

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES X NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Cardea M.D. | Md Gen'l Hospi | 10-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| B. | 10-13-49 | Glen Haven | Glen Burnie |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Huntington Williams, M.D. | James R. Kelly Corp. | 130 S. Fulton. |

VS 150

46F

G78890

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 491

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith M. Haynes

2. DATE OF DEATH: 10-9-49.

3. PLACE OF DEATH: A. Baltimore City, Maryland 646 Patapsco Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 70 Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 646 Patapsco Ave. 25-4

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M. | 10-1-1894 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home. | New Jersey | |

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Family - Same. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) myocarditis

DUE TO

ANTECEDENT CAUSES

(B) Bronchial Pneumonia

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Rubin M.D. | 243 Patapsco Ave | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 10-13-49. | Glen Haven | Glen Burnie |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | [illegible] | James L. McCauley | 130 S. Foot Ave. |

VS 150

92E

G78891

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78891 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lizzie M. Hardy

2. DATE OF DEATH: 10-10-49.

3. PLACE OF DEATH: A. Baltimore City, Maryland 3613 Brooklyn Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 20 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-24
D. STREET ADDRESS (If rural, give location): 3613 Brooklyn Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | 4-17-1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home. | W. Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Broadfield | Margaret ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, unless known) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Family - Same | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis
DUE TO
(B)
DUE TO
(C) Chronic Bronchitis
Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Rush M. D. | 203 Redwood | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 10-13-49 | Glen Haven | Glen Burnie |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Huntington Williams, M.D. | James L. McCauley | 1302 Fort Ave. 92c |

VS 150

G78892

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78892

BIRTH NO. 49-21720

Registered No.

1. NAME OF DECEASED (Type or Print): Baby "Girl" Leah King

2. DATE OF DEATH: OCT 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland (JOHNS HOPKINS HOSPITAL)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Perryman
D. STREET ADDRESS (If rural, give location): Box 146

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Child | 10-10-49 | | | | 20 | 47 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Frederick King

14. MOTHER'S MAIDEN NAME: Leah Hecksworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~atelectasis~~ pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs

DUE TO

(B) atelectasis

DUE TO

(C)

· ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-10, 1949, *to* 10-11, 1949, *that I last saw the deceased alive on* 10-11, 1949 *and that death occurred at* 4 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Andrews, M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Oct 12/49 | Belair Memorial Gardens | Belair Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 12 1949 | Registrar for Baltimore, Md. | Jos. J. Foster | Belair, Md |

VS 150

161a

G78893

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 54

4G78893 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Julia Ellen Moore

2. DATE OF DEATH: OCT 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgewood
D. STREET ADDRESS (If rural, give location): Post Chapel Army Chemical Center

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Child | 6-4-1949 | | 4 | 7 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harmon D. Moore
14. MOTHER'S MAIDEN NAME: Margaret Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Congenital malformation of the heart | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10, 1949, *to* 10-11, 1949, *that I last saw the deceased alive on* 10-11, 1949, *and that death occurred at* 10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 10/12/49 | Loudon Park | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Ulrich Funeral Home ADDRESS: 2008 Orleans St

VS 150

157E

G78894

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 G78894 Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELLEN SMART
2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1704 De Soto Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-52
D. STREET ADDRESS (If rural, give location): 1704 De Soto Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months: Days | If Under 24 Hours: Hours: Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Nov. 4, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore | |

13. FATHER'S NAME: Francis Quinn
14. MOTHER'S MAIDEN NAME: Ellen Gordon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Mrs. Alphonsine Voight | 1704 De Soto Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 10 days |
| DUE TO (B) | Cardiovascular renal disease | 7 mos. |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct, 1949 *to* Oct 10, 1949 *that I last saw the deceased alive on* Oct 9, 1949 *and that death occurred at* 3a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leo McCaffrey M. D. | 1710 Druid Blvd | Oct 11, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-13-49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1948 | Huntington Williams M.D. | George A. Farley | Baltimore & Fayette St. |

VS 150

131a

G78895

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 G78895 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Vincenzo Juliano

2. DATE OF DEATH: Oct. 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 906 Fawn St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. 60 Yrs — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 906 Fawn St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | January 6 1869 | 80 | 9 | 10 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer on B.O.R.R. (Ret.)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nusco Italy
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Carmelo Juliano
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles Juliano — ADDRESS: 906 Fawn St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertension
DUE TO
(B) myocarditis.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 7, 1949 *to* Oct 10, 1949, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry Gruber M. D.
23B. ADDRESS: 6006 Eastern Av
23C. DATE SIGNED: 10/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 13 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank Della Rocca — ADDRESS: 322 S. High St.

VS 150

92D

G78896 G78896

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): VICKERS, MR. ELMER —
2. DATE OF DEATH: 12 Oct 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hospital
c. Length of stay in Baltimore: 14 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerstown
D STREET ADDRESS (If rural, give location): 414 Gilford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | 29 June '04 | 45 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffer | — | Maryland | U.S.A. |

13. FATHER'S NAME: VICKERS, John
14. MOTHER'S MAIDEN NAME: HAMMOND, Barbara

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | Unknown | Self | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory arrest — Interval between onset and death: 10 min
DUE TO
(B) Bronchiectasis — 8 yrs
DUE TO
(C) Pulmonary Tbc — 10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 12 Oct 49 | Collapsed left lung & bronchiectasis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (Or, in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 27 Sept, 1949, *to* 12 Oct, 1949, *that I last saw the deceased alive on* 12 Oct, 1949, *and that death occurred at* 1:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard M. Garrett M. D. | Church Home + Hosp | 12 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | ADDRESS |
|---|---|---|---|---|
| Burial | Oct. 14-49 | Mountain View | Shepherdstown | Washington Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Hagerstown Williamsport, Md | Eddy & Sons | Williamsport Md |

VS 150

132

G78897

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G78897 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Betty Melba Kapp

2. DATE OF DEATH: 10/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D STREET ADDRESS (If rural, give location): 207 West North Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE (MARRIED) WIDOWED DIVORCED (Specify)
8. DATE OF BIRTH: Sept 19, 1912
9. AGE (In years last birthday): 37
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Women
10B. KIND OF BUSINESS OR INDUSTRY: Holzman Bakery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ivan Londsman
14. MOTHER'S MAIDEN NAME: Sarah Goldstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 216-10-3828
17. INFORMANT: Lawrence R Kapp
ADDRESS: Same -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio-vascular accident
DUE TO
(B)
DUE TO
(C) Chr cholecystitis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 hours -

19A. DATE OF OPERATION: 9/28/49
19B. MAJOR FINDINGS OF OPERATION: Cholecystectomy Appendectomy
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/21, 1949, to 10/11, 1949 *that I last saw the deceased alive on* 10/11, 1949, *and that death occurred at* 1:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. Martin M.D. M.D.
23B. ADDRESS: MARYLAND GENERAL HOSP.
23C. DATE SIGNED: 10/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: October 13/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D LOCATION (City, town, or county) (State): BALTIMORE, MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Lucinda Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson & Bros
ADDRESS: 1124-26 W. North Ave.

VS 150 432 61

127a

G78898 ✓ G78898

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Charles Franklin Mooney

2. DATE OF DEATH 10 - 11 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore: Yrs. 9 Mos. -01 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 517 E 38½ St.

5. SEX M
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Jan 14 1893
9. AGE (In years last birthday) 55 — If under 1 Year: Months 10 Days 27 — If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk.
10B. KIND OF BUSINESS OR INDUSTRY U.S. Post Office

11. BIRTHPLACE (State or foreign country) Lomoville Va
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Edward Mooney

14. MOTHER'S MAIDEN NAME Nancy Vann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO —

17. INFORMANT Mrs Mary B. Mooney ADDRESS 517 E 38½ St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Acute cardiac dilatation + congestive failure | a few minutes |
| DUE TO (B) | Chronic myocarditis | years ? |
| DUE TO (C) | Rheumatic heart disease | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Herpes zoster ascites Chronic passive congestion | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 - 8 - 49 *to* 10 - 11 - 49, *that I last saw the deceased alive on* 10 - 11, 1949, *and that death occurred at* 12 40 PM *from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Loria Callow
23B. ADDRESS Md. Gen'l Hosp
23C. DATE SIGNED 10 - 11

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 14 1949
24C. NAME OF CEMETERY OR CREMATORY Baltimore National
24D. LOCATION (City, town, or county) (State) Balto Md.

DATE RECEIVED LOCAL REG. OCT 13 1949
REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Dolan & Fox ADDRESS 2224 E Chase St

VS 150

2695

93c

CERTIFICATE CORRECTED 10-19-49

G78893

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903 G78893

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (Also known as JONAS VICIULIS) John Wiczulis — N-802

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 421 S. Bond St. 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 12-24-76 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jezen Wiczulis

14. MOTHER'S MAIDEN NAME: Ursula Safranowica

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 705-09-2737

17. INFORMANT: Johns Hopkins Hopkins Hospital ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia

DUE TO

(B) fracture of skull & intra-cranial hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 10-2-49

19B. MAJOR FINDINGS OF OPERATION: Cerebral contusion

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 421 S. Bond St. 3/1

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 2, 1949 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR?: Slipped & Fell to cement in alley

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: Emil L. Beyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Oct. 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/14/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery

24D. LOCATION (City, town, or county) (State): German Hill Road Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Mary Weber ADDRESS: 401 S. Chester St.

VS 151

186a

G78900

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78900

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel H. Rothrock

2. DATE OF DEATH: 10-12-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Md Gen'l Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 8-04
D. STREET ADDRESS (If rural, give location): 2328 E. Oliver St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 4 25 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Revenue Agent | Income Tax Dept Internal Revenue | Pa | |

13. FATHER'S NAME: [illegible] Rothrock

14. MOTHER'S MAIDEN NAME: Anna Hartman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Anna M. Kyle | 2328 E. Oliver |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Congestive failure | several wks unknown |
| DUE TO | Coronary artery disease | ? |
| (B) | Arteriosclerotic Heart Disease | years |
| DUE TO | and | ? |
| (C) | Diabetes mellitus | years |
| | Nephrosclerosis uremia | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-9 1949 *to* 10-12, 1949 *that I last saw the deceased alive on* 10-12, 1949, *and that death occurred at* 12:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Candler, M.D. | Md Gen'l Hosp. | 10/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/15/49 | Dulaney | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Tunstall Williams, M.D. | Wm. J. Kane | 1211 W. Pratt St. |

VS 150

11297

61

G78901

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78901

1. NAME OF DECEASED (Type or Print): Walter Clinton VonHagel

2. DATE OF DEATH: 10/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 608 N. East Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 26-10
D. STREET ADDRESS (If rural, give location): 608 N. East Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: June 16, 1886
9. AGE (In years last birthday): 63
If Under 1 Year: Months: 3 Days:
If Under 24 Hours: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Taxi-Cab
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Joseph VonHagel
14. MOTHER'S MAIDEN NAME: Julia Stone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-03-1667
17. INFORMANT: Rheta H. VonHagel
ADDRESS: 608 N. East Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: D. J. Lubenecky M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 10/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/15/49
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge
24D. LOCATION (City, town, or county) (State): Washington Boulevard.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frederick D. Miller, Inc. - 3019 E. Monument
ADDRESS:

VS 151

420 5V 8 94a

G78902

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78902

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Phoebe Buffington

2. DATE OF DEATH: Oct. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3628 Elm Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 12-06
D STREET ADDRESS (If rural, give location): 3628 Elm Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | May 10, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Christian Meyer | Catherine Ruff |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Catherine Bichell | 3628 Elm Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive CVD — 10 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Carcinoma, right breast — 2 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* February, 1949, *to* Oct. 11, 1949 *that I last saw the deceased alive on* Oct. 10, 1949, *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Donald Landon, M. D. | 6077 Harford Rd | 10-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/14/49 | St Mary's | Hampden. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, MD | Paul E. Lehmann & Co. | 36 S. Chester St |

VS 150

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G78903

BIRTH NO. 49-14274

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

795.4

G78903 Registered No.

1. NAME OF DECEASED (Type or Print): Ronald Hudson

2. DATE OF DEATH: Oct. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 300 N. Carey St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 300 N. Carey St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Single | July 6, 1949 | | 3 | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. | |

13. FATHER'S NAME: James Williams

14. MOTHER'S MAIDEN NAME: Christine Hudson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Christine Hudson | 300 N. Carey St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Undetermined (795.4)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

(over)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☒

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George L. Merrill M.D. | | Oct. 13, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 26. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | Charles Harper & Sons | 200 E Lanvale St |

VS 151

200 E ✓ av.

G78904 MASON

BALTIMORE CITY HEALTH DEPARTMENT 17° G78904

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine Mason

2. DATE OF DEATH: 10-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

c. Length of stay in Baltimore: Yrs. life Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 19-04
D. STREET ADDRESS (If rural, give location): 236 S. Mount st.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widow | Sept 13, 1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Md. | |

13. FATHER'S NAME: — Tivis

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Genevieve Bird | 106 S. Culver st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized metastatic CA | ? |
| DUE TO (B) | Carcinoma breast - left | ? |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-7-49 | Carcinoma - left breast | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-1 1949 *to* 10-11, 1949 *that I last saw the deceased alive on* 10-11, 1949 *and that death occurred at* 1 45 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. J. Kreedick M. D. | University Hosp | 10-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial 10/16/49 | | London Park | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Curtis Williams, M.D. | Harry H. Withers | 4101 Edmondson Ave |

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GM. 99898
G78905

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78905 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Hatchett

2. DATE OF DEATH: 10- 9- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 35 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 13 S. Bond St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min |
|---|---|---|---|---|---|---|
| Male | Negro | Married | Feb. 22, 188[illegible] | 63 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Laborer | General | Luenburg Va. | U.S.A. |

13. FATHER'S NAME: John Hatchett

14. MOTHER'S MAIDEN NAME: Betsy Jackson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | B.C.H. Records 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 3- 13- , 1946, *to* 10- 9- , 19 49, *that I last saw the deceased alive on* 10- 9- 1949, *and that death occurred at* 12.15 m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Logan M. D. | 4940 Eastern Ave. | 10-9-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 13. 49 | Mt Calvery Cem. | Brooklyn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 13 1949 | Tunstington Williams, M.D. | Elroy O. Wilson 1000 Brantly Ave. |

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G78906

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78906

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella McCann Grumbeine

2. DATE OF DEATH: 12 Oct. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital (DOA)
C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 5-01
D. STREET ADDRESS (If rural, give location): 1432 E BALTIMORE ST

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | WIDOWED. | FEB 22 1863 | 86 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WORK | AT HOME | BALTIMORE MD | U.S.A. |

13. FATHER'S NAME: CORNOULI'S MCCANN

14. MOTHER'S MAIDEN NAME: MARGARET 9.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | NONE | AGNES GRUMBEINE | 1432 BALTO ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, M.D. | | Oct. 12, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | OCT 14 1949 | NEW CATHEDRAL CEM | OLD FREDERICK RD MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | Duffel Bros | 1800 E LOMBARD ST |

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G78907 ✓ E 914.3 G78907

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CORBIN E. STEFFEY (CORBBLE E. STEFFEY) N-gr

2. DATE OF DEATH: Oct. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland (emw)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Key Highway Bethlehem Ship Repair Yd. Dispensary
C. Length of stay in Baltimore: 7 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-02
D. STREET ADDRESS (If rural, give location): 920 Trinity St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | 4-26-22 | 27 | 5 | 19 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | Shipyard | Orville, Va. | U.S.A. |

13. FATHER'S NAME: Ward Steffey

14. MOTHER'S MAIDEN NAME: Claudia N. Alvis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | W.W.2 | 231-01-8563 | Mrs. Corbin M. Steffey | 920 Trinity St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia, due to
DUE TO accidental electrocution

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Shipyard
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Bethlehem Ship Repair Yd., Key Highway
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 11, 1949 10:45 P m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? Electrocution (Was plugging extension cord into lamp)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 12, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 15/49 | Orville Va. | Orville Va. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank Fulla Agcy.
ADDRESS: 322 S. High 193 S. Haven. Balto. Md.

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G78908 G78908

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary M. Taylor
2. DATE OF DEATH: 10 - 10 - 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3208 Virginia Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 65 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 3208 Virginia Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | April 2/1857 | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none (Housewife) | none. (Home) | Harpers Ferry W. Va | U. S. A. |

13. FATHER'S NAME: Jacob Brown
14. MOTHER'S MAIDEN NAME: Emily Entler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | — |

17. INFORMANT: Mr. Walter B. Taylor ADDRESS: 3208 Virginia Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 7/14/49

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 14, 1949, to Oct 10, 1949 *that I last saw the deceased alive on* Oct 10, 1949, *and that death occurred at* 4.30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Alva D Bubert M. D. | 4803 Park Heights Ave | OCT 11-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 13/49 | Druid Ridge | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | Young Bros 5005 Park Hgts ave | 92 B |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DANIEL PATTERSON

2. DATE OF DEATH: 10/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 811 Mc Donough St.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 7-05
D. STREET ADDRESS (If rural, give location): 811 Mc Donough St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | Widowed | 3/4/1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | Belts Warehouse | Baltimore Md. | |

13. FATHER'S NAME: Daniel Patterson Sr.

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 213-09-8764 | Helen Pome | 811 Mc Donough St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection-Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 10/9/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/13/1949 | Mt. Calvary | Ann Arundel Co. Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Lucretia for Williams, M.D.
25. FUNERAL DIRECTOR: Randolph Gallick
ADDRESS: 1532 Biddle St.

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Dr. Cook
2431 Maryland Ave.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78910

BIRTH NO. G78910

1. NAME OF DECEASED (Type or Print): Anna E. Ackerman

2. DATE OF DEATH: Oct. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1913 Eutaw Place
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1913 Eutaw Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | 7/10/13/1874 | 74 75 | 0 / 1 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Harry A. Kohlerman, Fidelity Bldg. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial weakness | several years. |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertrophic arthritis. Arthritis deformans | several years |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 11 1949 1:20 P.M.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* Oct 11, 1949 *that I last saw the deceased alive on* Oct 10, 1949 *and that death occurred at* 1:20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Ellsworth Cook M. D.
23B. ADDRESS: 2431 Maryland Ave
23C. DATE SIGNED: Oct. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-14-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS: 5305 Harford Road.

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G78911 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78911 — Registered No.

1. NAME OF DECEASED (Type or Print): George E. Casson / George Edward Casson

2. DATE OF DEATH: 10-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 641 S. Grundy St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 21
D. STREET ADDRESS (If rural, give location): 641 S Grundy St. 26-09

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen Hosp.

c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Aug. 29, 1881 | 68 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handyman Penn. Railroad Retired 8 Yr.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. Casson
14. MOTHER'S MAIDEN NAME: Susannah Hawkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Gwendolyn Casson 641 S Grundy St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hepato-renal failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-11, 19 49, *to* 10-13-49, 19 __, *that I last saw the deceased alive on* 10-11, 19 49, *and that death occurred at* 6 3-A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jos Shea M.D. | W B G H. | 10/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 16, 49 | Oaklawn cemetery | Baltimore Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Henry Sander & Sons Inc. Baltimore Md.

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G78912

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78912 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOUISE CATHERINE SEWELL

2. DATE OF DEATH: Oct.11.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2905 Shirey Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore-14 27-03
D. STREET ADDRESS (If rural, give location): 2905 Shirey Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Feb.14.1873 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | - - - | Baltimore Md. | USA |

13. FATHER'S NAME: John A. Ries

14. MOTHER'S MAIDEN NAME: Mary M. Lambert

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Haskell J. Sewell | 2905 Shirey Av.e-14 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 2 weeks |
| DUE TO (B) | Cerebral Arteri-Sclerosis | Symptoms noted for several months |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Vascular Changes | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Right side Hemiplegia, Speech etc | Several months |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Sept. 20, 1949, *to* Oct. 11, 1949, *that I last saw the deceased alive on* Oct. 11, 1949, *and that death occurred at* 5.30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. F. Ries M. D. | 24 S. Broadway | Oct. 13, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct.14.1949 | Oak Lawn Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS. INC. | Baltimore Md. |

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G78913 B.C. G-39589 BALTIMORE CITY HEALTH DEPARTMENT 54-4 G78913
BIRTH NO. CERTIFICATE OF DEATH Registered No.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) **Ernest Wheeler Norris, Jr.** | | | 2. DATE OF DEATH **Oct. 12, 1949** |
| 3. PLACE OF DEATH: A. **Baltimore City, Maryland** | | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Md.** B. COUNTY | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2301 Tucker Ave.,** | | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 28-03 | |
| c. Length of stay in Baltimore **3--** Yrs. Mos. Days | | D. STREET ADDRESS (If rural, give location) **2301 Tucker Ave.,** | |
| 5. SEX **Male** | 6. COLOR OR RACE **White** | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) **Single** | 8. DATE OF BIRTH **Jan. 7, 1946** |
| 9. AGE (In years last birthday) **3** | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **none** | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) **Baltimore, Md.** | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME **Ernest W. Norris** | | 14. MOTHER'S MAIDEN NAME **Ruby M. Jackson** | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **no** | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO **none** | 17. INFORMANT **Ernest W. Norris** ADDRESS **2301 Tucker Ave.,** |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Congenital Heart Disease | 4 yrs. |
| | DUE TO | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Pneumonia - Malnutrition | 4 days - |
| | DUE TO | | |
| | (C) | Maldevelopment of Body & Cleft palate | — |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Born Life - one week/ Artificial Respiration | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 10-9 19 49 *to* 10-12 19 49 *that I last saw the deceased alive on* 10-12 19 49 *and that death occurred at* 10 A.M. *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE **Dr. Thos. J. Abbott** M.D. | 23B. ADDRESS **4305 Liberty Heights Ave** | 23C. DATE SIGNED **10-12-49** |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial** | 24B. DATE **10-15-49** | 24C. NAME OF CEMETERY OR CREMATORY **Lorraine Park** 24D. LOCATION (City, town, or county) **Woodlawn** (State) **Md.** |
| DATE RECEIVED BY LOCAL REGISTRAR **OCT 13 1949** | REGISTRAR'S SIGNATURE **Hunter Williams, M.D.** | 25. FUNERAL DIRECTOR **G. Howard Strong** ADDRESS **3207 W. North Ave.,** |

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G78914

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78914

Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) **Samuel Amos Reed** | 2. DATE OF DEATH **Oct.11,1949** |
| 3. PLACE OF DEATH: A. **Baltimore City, Maryland** | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Md.** B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1838 Orleans St.,** | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** |
| c. Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) **1838 Orleans St.,** 6-04 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **Male** | **White** | **Widowed** | **Feb.19,1883** | **66** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **Retired** | **Rogers Towing Co.** | **Md.** | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| **Samuel A. Reed** | **Sarah Ann Younger** |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | **217-14-5110** | **Miss Sadie M.Reed** | **1838 Orleans St.,** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Respiratory failure**

DUE TO

(B) **Cirrhosis Liver (Laennec's)**

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. **Arteriosclerotic Cardiovascular disease**

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 48 *to* Oct 11, 1949 *that I last saw the deceased alive on* Oct 1, 1949, *and that death occurred at* 3.00 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **G Abrafsky M.D.** M. D. | **601 N. Monroe St** | **10/12/49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **10-14-1949** | **Mt.Olivet** | **Baltimore, Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | **G.Howard Strong** | **3207 W.North Ave.,** |

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G78915

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

171

Registered No. G78915

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Poe

2. DATE OF DEATH 10/11/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland 927 Wilmot Ct

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 58 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 927 Wilmot Ct. Balto. Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore Md.
D. STREET ADDRESS (If rural, give location) 927 Wilmot Ct. 10-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH (Month) (Day) (Year) | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | Married. | 9/22/1869 | 79 | | 19 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife. | Housework | Texas. Md. | U.S |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Mahlon Poe | Mrs Ida Roebuck. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Francis Burke Daughter | 1638 Normandy |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of cervix

DUE TO (B) Liver metastases

DUE TO (C) Cardiac failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) 5 yrs.
(B) 2 mths.
(C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/25 19 48, *to* 10/11 19 49 *that I last saw the deceased alive on* 10/10, 19 49 *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. A. MacMurchy M. D. | 801 Bureau St. | 10/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/14/49 | Loudon Park | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Hunter for Williams, M.D. | Frederick A. Cole | 1913 N. Baltimore St. |

VS 150

48a

G78916

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 31

Registered No. G78916

1. NAME OF DECEASED (Type or Print): JOHN T. BOOTH.

2. DATE OF DEATH: 10/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 26-09
D. STREET ADDRESS (If rural, give location): 511 S. Conkling St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | May 1/86 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Councilman | | Md | |

13. FATHER'S NAME: William Booth

14. MOTHER'S MAIDEN NAME: Anna Master

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro vascular accident

DUE TO

(B) Hypertension

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Coronary Fibrillation
Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/7 19 49 *to* 10/10 19 49, *that I last saw the deceased alive on* 10/10 19 49 *and that death occurred at* 7:10 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Black M.D. | Maryland General | 10/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/14/49 | Oak Lawn | 7225 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 13 1949 | Custavator Williams, M.D. | Clarence F. Hoffmann 1639 Broadway |

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G78917

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

74

Registered No. G78917

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lola V. Frank

2. DATE OF DEATH: 10/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2829 Harview Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-07
D. STREET ADDRESS (If rural, give location): 2829 Harview Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | July 16, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Baltimore | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Wilson | not known |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| | | Mrs. A, Denver 2829 Harview Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO

(B) Carcinoma of Uterus - Metastasis

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 7, 1947 *to* Oct 12, 1949 *that I last saw the deceased alive on* Oct 10, 1949, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles Kenworthy M. D. | 2324 Eastern Av. | 10/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Moreland Mem. | Taylor Ave. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949

REGISTRAR'S SIGNATURE: Lucinda Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

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MS—132222 G78918

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 271.7 G78918 Registered No.

BIRTH NO.

N-971

1. NAME OF DECEASED (Type or Print): Harry Granruth

2. DATE OF DEATH: 10-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 104 N. Wolfe St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June 24-1898 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Granruth
14. MOTHER'S MAIDEN NAME: Annie Barringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records
ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paranoia coma acute
DUE TO
(B) Barbiturate toxicity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R. B. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Hospital
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Baltimore City Hospitals
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-11-49 3 P. m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Overdose of Sodium Phenobarbitol Administered as medication

22. *I hereby certify that I attended the deceased from* 9-29-, 1949, *to* 10-11-, 1949 *that I last saw the deceased alive on* 10-11-, 1949, *and that death occurred at* 10:15 PM *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Logan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/15/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Carmel
24D. LOCATION (City, town, or county) (State): O'Donnell St
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: OCT 13 1949
REGISTRAR'S SIGNATURE: Emerson Williams, M.D.
25. FUNERAL DIRECTOR: Clarence P. Hoffman

TO BE APPROVED BY MEDICAL EXAMINER

179B

G78919 B.C. 49-22554

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 3 4

G78919

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Rosalie A. Tripp

2. DATE OF DEATH: 10/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 680 W Saratoga St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md 4-02

c. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 680 W Saratoga St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | | 4-10-45 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | BALTO. MD | |

13. FATHER'S NAME: Floyd Adams

14. MOTHER'S MAIDEN NAME: Henrietta Tripp

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Henrietta Tripp | 680 W. Saratoga St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Palsy

DUE TO

(B) Intracranial Hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection *Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|---|
| P. J. Turbeville | | | 10/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-8-49 | Mt. Calvary Cemetery | Cedar Hill Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | William H. Jackson | 916 Penna. Ave. |

VS 151

8-7E

G78920 JL - 131152 BALTIMORE CITY HEALTH DEPARTMENT 49 G78920

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): William Butler

2. DATE OF DEATH: 10-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1028 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Wid. | Dec. 25, 1879 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | N. C. | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B. C. H. Records, | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lung abscess --due to Bronchpneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchiectasis

DUE TO

(C) Generalized arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

asymtomatic neurosyphilis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] Yes NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8-18-49, 19, *to* Oct. 10, 19 49 *that I last saw the deceased alive on* Oct. 10, 19 49 *and that death occurred at* 12.25 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 4940 Eastern Ave. | 10-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 10-14-49 | Mt. Auburn Cemetery | A. A. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | William E. Jackson | 976 Pennsylvania Ave |

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G78921

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1 G78921

BIRTH NO. G78921

1. NAME OF DECEASED (Type or Print): Thomas Joseph Murphy

2. DATE OF DEATH: 10/11/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1506 E.Lanvale Street
c. Length of stay in Baltimore: 48 Yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1506 E.Lanvale Street 8-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Oct.22nd.1876 | 72 | 11 | 19 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Plumbing Supply Co. | Ireland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick Murphy | ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 212-01-1318 | Mrs.Margaret Wright | 1506 E.Lanvale St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Coronary occlusion | 4 days |
| DUE TO (B) | Hypertensive heart disease | 1 year |
| DUE TO (C) | Angina Pectoris | 9 mos. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan. 17 1949 *to* Oct. 11, 1949 *that I last saw the deceased alive on* Oct 11, 1949 *and that death occurred at* 11 07 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. H. Frenzer M. D. | 1402 E. Lanvale St | 10.13.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-14-49 | New Cathedral Cemetery | Edmondson Ave.Balto.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 13 1949 | Huntington Williams, M.D. | George J.Ruth,Inc. | 1735 Harford Avenue |

VS 150

93D

G78922

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78922

1. NAME OF DECEASED (Type or Print): William H. Ruby

2. DATE OF DEATH: 10/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1322 Sargeant St
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 21-04
D. STREET ADDRESS (If rural, give location): 1322 Sargeant St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 12/28/840 | 59 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Canman
10B. KIND OF BUSINESS OR INDUSTRY: B. O R.R.
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Chas. T. Ruby
14. MOTHER'S MAIDEN NAME: Hannie Berry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 705-04-3421
17. INFORMANT: Lottie M. Ruby ADDRESS: 1322 Sargeant St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: C. S. Tulenko M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 10/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/17/49
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): A. G. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Cook Inc. ADDRESS: 217 E. Pratt St.

VS 151

94a

G78923

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78923

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elmer Hayes

2. DATE OF DEATH: 10/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Rd 11-01
D. STREET ADDRESS (If rural, give location): 606 N. Calvert St

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Jan 15th 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Assistant Cook | Suburban Club | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William F. Hayes | Laura (Unknown) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Laura G. Hayes | 701 Mura St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|---|
| C. L. Schleicher | | | 10/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/15/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 217 St. Paul St. |

VS 151

93D

G78924 MS—132315

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

605 G78924

BIRTH NO. 7 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Gaither - Hilda

2. DATE OF DEATH: 10-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 7 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 513 Bridgeview Road --25

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 3, 1949 | | | | 7 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Calvin Gaither

14. MOTHER'S MAIDEN NAME: Hilda Wright

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B. C. H. Records, | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage ; Fetal Atelectasis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Prematurity DUE TO
(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Oct. 3, 1949, *to* Oct. 3, 1949 *that I last saw the deceased alive on* Oct. 3, 1949, *and that death occurred at* 3:20 Pm., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Ave. | 10-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremated | 10-6-49 @ 9:00AM | Baltimore City Hospitals | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Turrington Williams, M.D. | | |

VS 150

160a

G78925 JL -132000

BIRTH NO. 49-20103

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78925

1. NAME OF DECEASED (Type or Print): Baby Boy Williams - Annie

2. DATE OF DEATH: 9-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital 4940 Eastern Ave.

c. Length of stay in Baltimore: 11 days (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5607 Woodlock Ct.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Single | Sept. 19, 1949 | | | 11 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Eugene Williams

14. MOTHER'S MAIDEN NAME: Annie Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | B. C. H. Records, 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diarrhea

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES Yes NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 19, 1949 *to* Sept. 30, 1949, *that I last saw the deceased alive on* Sept. 30 1949 *and that death occurred at* 10.20 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Rogers M. D. | 4940 Eastern Ave. | 10-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremated | 10-8-49 | B. C. H. Crematory | 4940 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | | |

VS 150

159

G78926 Nitsch X ✓ G78926

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

56 ✓ Registered No.

BIRTH NO. 49-19911

1. NAME OF DECEASED (Type or Print): Baby Girl Nitsch

2. DATE OF DEATH: 10/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
C. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY, Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28
D. STREET ADDRESS (If rural, give location): 307 Englewood Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 9/16/49 | | 26 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Nitsch
14. MOTHER'S MAIDEN NAME: Catherine Taya

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: John Nitsch ADDRESS: 307 Englewood Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis & aspiration pneumonitis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Aspiration of milk

DUE TO Congenital malformation of ~~the~~ mandible & prolapse of tongue with cleft palate — 26 days

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cystic right kidney

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/16 1949 *to* 10/12, 1949 *that I last saw the deceased alive on* 10/12, 1949, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leland D. Lukes M.D. | St Agnes Hosp. | 10/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/14/49 | Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | George A. Farley | Fulton over Fayette |

VS 150

157M

G78927

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78927

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosa Lee Richardson Burgess

2. DATE OF DEATH: Oct. 13 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2614 Hollings Ferry Road

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 25-33
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Winans
D. STREET ADDRESS (If rural, give location): 2614 Hollings Ferry Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | married | Sept 5 1893 | 57 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Sumpter S. C. | U. S. A. |

13. FATHER'S NAME: Ezekiel Baker

14. MOTHER'S MAIDEN NAME: Emma

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Embray Burgess ADDRESS: 2614 Hollings Ferry

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

(B) Malegnant Hypertension — 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 19 49 *to* Oct 12 19 49 *that I last saw the deceased alive on* Oct 19 49, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Schofield M. D. | 2201 Arunsdale Rd | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Interment | 10/17/49 | Florence - S. C. | South Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | A. Halstead | 918 Druid Hill Ave |

VS 150

83a

BIRTH NO. C78928

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C78928

1. NAME OF DECEASED (Type or Print): HELEN H. JOHNSON
2. DATE OF DEATH: 10-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1229 ASHLAND AVE
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 10-07
D. STREET ADDRESS (If rural, give location): 1229 ASHLAND AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C. | Widow | 2-22-1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | BALTIMORE, Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HENRY HAZELTON | HARRIETT |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | ELIZABETH EVANS | 1229 ASHLAND Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) —

DUE TO

(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-7-, 1949, *to* 10-12, 1949, *that I last saw the deceased alive on* 10-11-, 1949, *and that death occurred at* 4.55 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. H. Cargill M. D. | 611 N. Carolina St | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-15-49 | MT. CALVARY | A.A. COUNTY, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 16 1949 | Huntington Williams, M.D. | Joseph B. Looks, Jr. | 1304 N. Central Av |

131a

G78929

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G78929

1. NAME OF DECEASED (Type or Print): Ernestine McFadden

2. DATE OF DEATH: Oct. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 223 Myrtle Ave. 4-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | W. | Sept. 1, 1922 | 27 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO., Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John H. Bright
14. MOTHER'S MAIDEN NAME: SALLIE BEATRICE P.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: NAOMI BARNES ADDRESS: 1019 N. CENTRAL Av

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Syphilis of brain (general paresis) (Cause)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 12, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-15-49 | MT. CALVARY | A.A County, Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph L. Rocks, Jr. ADDRESS: 1304 N. Central Av

VS 151

30C

G78930

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78930

1. NAME OF DECEASED (Type or Print): ROSINA A. EISENBRANDT

2. DATE OF DEATH: Oct. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4315 Marble Hall Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4315 Marble Hall Rd. 27-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | Mar. 3, 1869 | 80 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | home | Bedford Co., Pa. | |

13. FATHER'S NAME: Henry Allen

14. MOTHER'S MAIDEN NAME: Emeline Rickey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| – | | Mrs. Emeline Boucher | Bethesda, Md. 4831 West Lane. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocarditis | Years. |
| DUE TO (B) | Arteria-Sclerosis - generalized | Years. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July, 1943, *to* October 13, 1949 *that I last saw the deceased alive on* Oct 12, 1949, *and that death occurred at* 9:15 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry L. Henderson M. D. | 20 E. Preston St. Balto-2, | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10.15.49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

G78931

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 17°

G78931

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ETTA S. HENNELLY

2. DATE OF DEATH: Oct. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2030 Hollins St.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2003 2030 Hollins St.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 25, 1889
9. AGE (In years last birthday): 60 yrs. (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier
10B. KIND OF BUSINESS OR INDUSTRY: Meat
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry Seibel
14. MOTHER'S MAIDEN NAME: Louisa
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Carl W. Seibel ADDRESS: 4808 Liberty Hgts. Av

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of right breast — INTERVAL BETWEEN ONSET AND DEATH: about 3 yrs.
DUE TO
(B) Metastasis to various parts of free body, including liver & left pleura.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Aug 29, 1949 *to* Oct 13, 1949 *that I last saw the deceased alive on* Oct 13, 1949, *and that death occurred at* 7 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Kadow M. D.
23B. ADDRESS: 2306 Eutaw Pl
23C. DATE SIGNED: 10-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/15/49
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Cem.
24D. LOCATION (City, town, or county) (State): Howard Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

50

G78932

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59

G78932

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Phillip Booze

2. DATE OF DEATH: Oct. 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1344 Division St.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-P
D. STREET ADDRESS (If rural, give location): 1344 Division St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | July 1886 | 63 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Booze

14. MOTHER'S MAIDEN NAME: Bath?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lillie Booze ADDRESS: 1344 Division St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema & Anasarca — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

DUE TO

(B) Acute Congestive Failure & "Aortic Regurgitation" — 4-5 mo.

DUE TO

(C) Chr. Glomerular Nephritis. Unknown & Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 1948 *to* Oct 11, 1949 *that I last saw the deceased alive on* Oct 11, 1949, *and that death occurred at* 7:30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Garland Shindell M. D. | 902 W. Franklin | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 10/14/49 | Mt. Auburn | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | A. Halstead | 918 Druid Hill Ave. |

VS 150

131a

G78933

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

G78933

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CHRISTIAN BUTT

2. DATE OF DEATH: October 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3337 Dudley Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Lifetime Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3337 Dudley Ave. 26-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | May 24, 1883 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police lieutenant-retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Butt

14. MOTHER'S MAIDEN NAME: Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: John T. Butt ADDRESS: 3108 Kenyon Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

DUE TO

(B) Hypertension Cerebral arteriosclerosis

DUE TO

(C) Hypertension Arterio sclerotic Cardio-Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 12, 1949 *to* Oct 12, 1949 *that I last saw the deceased alive on* Oct 12, 1949 *and that death occurred at* 6.30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: K Kruleavitz M. D.

23B. ADDRESS: 244 N Hilton St.

23C. DATE SIGNED: 10/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 17, 1949

24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Memorial Park

24D. LOCATION (City, town, or county) (State): Elkridge, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Ulrich Funeral Home ADDRESS: 2008 Orleans St.,

VS 150

937

G78934

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78934

1. NAME OF DECEASED (Type or Print): MARY KAROLKOWSKI

2. DATE OF DEATH: Oct. 12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fairfield Nursing Home 1913 Eutaw Pl.
C. Length of stay in Baltimore: 48 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: M.D.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26 - 05
D. STREET ADDRESS (If rural, give location): 407 S. Gusryan Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | 1/2/92 | 57 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | At home | Poland | U.S.A. |

13. FATHER'S NAME: HILARY - WOJCIK

14. MOTHER'S MAIDEN NAME: ? ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | KARL KAROLKOWSKI | 407 GUSRYAN St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | KIDNEY FAILURE | 3 months |
| DUE TO (B) | DECUBITUS ULCERS, ADVANCED | 12 months |
| DUE TO (C) | HYPERTROPHIC ARTHRITIS | several yrs |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 1, 1949, *to* Oct. 12, 1949, *that I last saw the deceased alive on* Oct. 11 49 49, *and that death occurred at* 9:15 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Ellsworth Cole M.D. | 2431 Maryland Avenue Balto 18 | 10/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/15/49 | Holy Rosary | Balto - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | Lilly & Zerbe | 403 S. Wolfe St |

VS 150

590

G78935

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78935

BIRTH NO. 49-01652

1. NAME OF DECEASED (Type or Print): Lucille Langley

2. DATE OF DEATH: Oct. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26 - 34
D. STREET ADDRESS (If rural, give location) 1033 Skaugler Way

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp.

c. Length of stay in Baltimore: Yrs. LIFE Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 1-25-79 | 8 | | 8 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Md | U.S.A. |

13. FATHER'S NAME: Lowe Langley

14. MOTHER'S MAIDEN NAME: Leebin (Lillian) Fleischman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Leukemia, myelogenous
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9/27, 1949 *to* 10/12, 1949, *that I last saw the deceased alive on* 10/12, 1949, *and that death occurred at* 10 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W. Haury M. D. | JOHNS HOPKINS HOSPITAL | 10-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/15/49 | Oak Lawn | Balto. Co |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | Willy V Zeiler Inc. | Balto. |

VS 150

74a

G78936

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

401.3

G78936 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Shirley Smith

2. DATE OF DEATH 10-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14 03
D. STREET ADDRESS (If rural, give location) 1900- Druid Hill Ave

5. SEX female
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH June 2, 1934
9. AGE (In years last birthday) 15 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Smith
14. MOTHER'S MAIDEN NAME Caroline Pittman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. William Smith ADDRESS 1900 Druid Hill Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic Carditis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1 1949, *to* 10-12, 1949, *that I last saw the deceased alive on* 10-12 1949, *and that death occurred at* 6 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE A. Brady M.D.
23B. ADDRESS Provident Hospital
23C. DATE SIGNED 10-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 15, 1949
24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Holland Funeral Home 1631 Druid Hill Ave.

VS 150

581

G78937

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78937

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph St. Clair Lowsome

2. DATE OF DEATH: Oct. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1805 Greatman St.

c. Length of stay in Baltimore: 49 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-07
D. STREET ADDRESS (If rural, give location): 1805 Greatman St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | married | June 6, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | | Baltimore, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Washington Lowsome | Kate Washington |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Mozelle Lowsome | 1805 Greatman St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Oct 1949
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-10, 1949 *to* 10-12, 1949 *that I last saw the deceased alive on* 10-11, 1949, *and that death occurred at* 5:10 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 803 W Fremont St | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 16, 1949 | Mt. Zion | Balto Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

12B

G78938

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78938

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Burdett, Martha

2. DATE OF DEATH: Oct 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hendyted
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Fe | Negro | Married | April 10, 1902 | 47 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Martin Whiten
14. MOTHER'S MAIDEN NAME: Amy Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Martin Whiten ADDRESS 2536 Mc Culloh St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Respiratory Arrest | 3 hrs. |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Pneumonia | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-12-49 | Tbc Rt upper lobe | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 7, 1949, *to* Oct 12, 1949, *that I last saw the deceased alive on* Oct 12, 1949, *and that death occurred at* 6.40 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G W Bodymiller M. D. | Hamilton Sq Bldg | 10-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 14, 1949 | Arbutus Mem. Pk. | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Thurlington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

13D

G78939

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

Registered No. G78939

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maggie Sales

2. DATE OF DEATH: Oct. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1217 McCulloh St.

c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1217 McCulloh St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | Nov. 20, 1876 | 72 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jim Smith

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles Sales ADDRESS: 1217 McCulloh St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular disease — DUE TO

(B) Hypertension — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized Arteriosclerosis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 18, 1949 *to* Oct. 11, 1949, *that I last saw the deceased alive on* Oct. 6, 1949 *and that death occurred at* 5:00 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: E. Wallis Sherwood M. D.

23B. ADDRESS: 701 N. Carey St.

23C. DATE SIGNED: 10/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 15, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Westport, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Charles H. Alexander ADDRESS: 1200 McCulloh St. Balt. Md.

VS 150

937

G78940

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

586 Registered No. G78940

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Washington

2. DATE OF DEATH: OCT 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md
B. COUNTY: 17-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1126 Druid Hill Ave

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 4-7-1893
9. AGE (Last birthday): 56 — If under 1 Year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Allen Washington
14. MOTHER'S MAIDEN NAME: Harriett James

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Postoperative collapse - | 24 hrs |
| DUE TO | | |
| (B) | Generalized debilitation | 3 yrs. |
| DUE TO | | |
| (C) | Biliary obstruction | 5 yrs. |

19A. DATE OF OPERATION: 10-10-49
19B. MAJOR FINDINGS OF OPERATION: Stricture of cholangio-jejunostomy
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17-49 *to* 10-11-49 *that I last saw the deceased alive on* 10-11-49 *and that death occurred at* 2:08 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul C. Johnis, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 16
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Westport Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Charles H. Alexander — ADDRESS: 1200 McCulloh St

VS 150

1220

G78941

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450.1

G78941

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Gibson Dorsey

2. DATE OF DEATH: Oct 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1114 Whatcoat st

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1114 Whatcoat st 16 02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | married | July 14, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | md | |

13. FATHER'S NAME: Dennis Simmons

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Robert Dorsey | 1114 Whatcoat st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene of right foot — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-6 19 49 *to* 10-12 19 49 *that I last saw the deceased alive on* 10-12 19 49 *and that death occurred at* 8 30/60 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Stanford P. Bussard M. D. | 2309 Druid Park Drive | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Arbutus Memorial Pk. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, MD | Geo. A. Nelson & DeBruecker Co. | |

VS 150

97

G78942 ✓ 44 ✓ G78942

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edna M. Wise

2. DATE OF DEATH: Oct 13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 139 W. Hamburg
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 139 W. Hamburg St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 23-01
D. STREET ADDRESS (If rural, give location): 139 W. Hamburg St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | June 6. 1907 | 42 | 4 / 7 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Nurse | | Balto | |

13. FATHER'S NAME: James Hopkins

14. MOTHER'S MAIDEN NAME: Fannie E. Wise

| 15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Catherine Wise | 139 W. Hamburg |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial

DUE TO

ANTECEDENT CAUSES

(B) Hypertension Nephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 15, 1949 *to* Oct 13, 1949 *that I last saw the deceased alive on* Oct 13, 1949 *and that death occurred at* 5 a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D.W. Trumbo M. D. | 1111 Lee | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 17 49 | Mt. Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | James A. Hayes | 638 N. Gilmor St |

VS 150

937

G78943

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

G78943

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Amanda Snyder ~~Snyder~~ Edmondston

2. DATE OF DEATH: Oct. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-04
D. STREET ADDRESS (If rural, give location): 738 East 30th Street

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 13, 1877
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Andrew Snyder
14. MOTHER'S MAIDEN NAME: Sarah Barger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Union Memorial Hospital ADDRESS: Reroads

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 9, 1949 *to* October 14, 1949 *that I last saw the deceased alive on* October 14, 1949, *and that death occurred at* 9 45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William A. Ramsay M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: Oct 14 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-17-49
24C. NAME OF CEMETERY OR CREMATORY: ROSE HILL
24D. LOCATION (City, town, or county) (State): HAGERSTOWN, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George L. Schwab ADDRESS: 2101 Frederick Ave.

VS 150

93D

G78947 BALTIMORE CITY HEALTH DEPARTMENT 180 Registered No. G78947

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY A. BEAUMONT

2. DATE OF DEATH Oct. 12-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 631 Wordington Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 79 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-08
D. STREET ADDRESS (If rural, give location) 631 Wordington Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | married | Aug. 6-1870 | 79 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman
10B. KIND OF BUSINESS OR INDUSTRY B+O R.R. Car Repair
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Alexander A. Beaumont
14. MOTHER'S MAIDEN NAME Margaret Schaefer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Mattie M. Beaumont ADDRESS 613 Washington Rd

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, left Kidney — ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Oct. 12, 1949 *that I last saw the deceased alive on* Oct 11, 1949 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D C MacLaughlin | 4509 Edmondson Village (State) | 10/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) |
|---|---|---|---|
| Burial | Oct 15-49 | Mt. Olivet | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR OCT 14 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS Geo. K. Berger Jr 1732 Hollins St

VS 150

52a

G78945

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78945 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Ida B. Ward
2. DATE OF DEATH: 10.14.49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 231 Mallow Hill Rd. - Balto. 29, Md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M. | 4.9.83 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: James E. Poole
14. MOTHER'S MAIDEN NAME: Mary A. Fillinger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Thomas J. Ward ADDRESS: 231 Mallow Hill Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Coronary Occlusion.
DUE TO
(B) Coronary Heart Disease
DUE TO
(C) Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 13, 1949, to October 14, 1949, *that I last saw the deceased alive on* October 14, 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: O. J. Castellano M. D.
23B. ADDRESS: Bon Secours Hospital
23C. DATE SIGNED: 10.14.49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/17/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowen & Son ADDRESS: Hollins St.

94a

G78946 G78946

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Pearl Richards

2. DATE OF DEATH: 10/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Home of Our Lady

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 1302 W. Lexington St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 7/12/1878
9. AGE (In years last birthday): 71 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Richards
14. MOTHER'S MAIDEN NAME: Molley Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Roslyn Buettner ADDRESS: 1130 Cleveland St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Cardio vascular disease — ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 12, 1949 *to* Oct 12, 1949 *that I last saw the deceased alive on* Oct 12, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Glassman M. D.
23B. ADDRESS: 25 3 W. Fayette St
23C. DATE SIGNED: Oct 13 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/17/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Western Cem.
24D. LOCATION (City, town, or county) (State): Edmondson Ave + Longwood St.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John J. Cowan + Son ADDRESS: 9 Collins St.

VS 150

93D

G78947

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51 ✓

G78947

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Anthony Rapagna — RAPAGNA

2. DATE OF DEATH: 10/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-06
D. STREET ADDRESS (If rural, give location): 335 S. Ellamont St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | 11/5/79 | 70 | 8 | 27 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER - P.P.R.R (RET.)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: LORENZO RAPAGNA

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

DUE TO

(B) Cause unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 10, 1949 *to* Oct. 17, 1949 *that I last saw the deceased alive on* Oct. 17, 1949 *and that death occurred at* 10:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul J. Manning M. D.

23B. ADDRESS: Bon Secours Hospital

23C. DATE SIGNED: 10/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: OCT 15-49

24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL-CE

24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Frank Dellaboca 327 S High St.

VS 150

129

CERTIFICATE CORRECTED 10-18-49

G78948

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50 Registered No. G78948

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Harris

2. DATE OF DEATH Oct. 14-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 604 S. Eutaw St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 46 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 604 S. Eutaw St. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 604 S. Eutaw St 12-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | Dec. 25-1902 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Truck Helper | Grocery | Balto. Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Levern Harris | Fannie Eutaw |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | | Rachel Harris | 604 S Eutaw St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. it means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Carcinoma Esophagus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Secondary Lues

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 48 *to* Oct 14, 1949 *that I last saw the deceased alive on* Oct 10, 1949 *and that death occurred at* 12.45 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Slorofsky M.D. M.D. | 601 N. Monroe St. | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Oct 17-49 | Mt. Auburn Cemetery | Balto. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Huntington Williams, M.D. | Walter B. Spiggle | 1391 W. Hamburg St. |

VS-150

46a

G78949

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78949

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES A. FAMBACK.

2. DATE OF DEATH: October 13-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: Life. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 38-S. Calverton Road. 20-04

5. SEX: Male.
6. COLOR or RACE: White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: Feb. 24-1886
9. AGE (In years last birthday): 63 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist.
10B. KIND OF BUSINESS OR INDUSTRY: Automobile.
11. BIRTHPLACE (State or foreign country): Baltimore - Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Andrew Famback.
14. MOTHER'S MAIDEN NAME: Mary Heddinger.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes. World War No. 1.
16. SOCIAL SECURITY NO.: 217-09-8366
17. INFORMANT: Mrs. Margaret J. Fambach. ADDRESS: 38-S. Calverton Rd.

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion & myocardial infarction.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 8-9 hrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 13, 1949 *to* Oct 13, 1949 *that I last saw the deceased alive on* Oct. 13, 1949, *and that death occurred at* 12:50A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul S. Fanning M. D.
23B ADDRESS: Bon Secours Hosp.
23C DATE SIGNED: 10/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: Oct. 17-1949.
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D LOCATION (City, town, or county) (State): Baltimore - Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles J. Schwab
ADDRESS: 3512-Frederick Ave.

VS 150

94a

G78950

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78950 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Genevieve J. Howland

2. DATE OF DEATH: 10-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3909 Coldspring Lane

c. Length of stay in Baltimore: 12 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15-10
D. STREET ADDRESS (If rural, give location): 3909 W. Coldspring Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | 12-3-1868 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | New York | |

13. FATHER'S NAME: Edmond J. Burke

14. MOTHER'S MAIDEN NAME: Cecilia A. Fuller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Laurance D. Oppenheim ADDRESS 3904 W. Coldspring

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 6-10, 1949 to 10-12, 1949 *that I last saw the deceased alive on* 10-11, 1949 *and that death occurred at* 12:10 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. D. Flynn M. D. | 11 E. Chase St | 10-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-15-49 | New Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Carlington Williams, M.D. | John A. Moran | 3000 E. Balt. St. |

93D

G78951

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 G78951 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Moriss Andrews

2. DATE OF DEATH: Oct. 12, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: 32 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1723 E. Biddle St. 8 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year, last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | M. | 2-5-1896 | 53 yrs | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Ashland Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Lee Andrews | Betsy Buckner |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Linds[illegible] Andrews | 596 E. 165 N.Y. |

MEDICAL CERTIFICATION

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George L. Merrill M.D. | | Oct. 12, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Sat. Oct. 15th 1949 | Mt Calvary | a. a. co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 14 1949 | Thurlington Williams, M.D. | Byron & Mamie Knight | 72 Augusta |

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G78952 X ✓ G78952

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 60

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ada Jessie Brown Fitzgerald

2. DATE OF DEATH Oct 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Four (Years / Months / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oxford
D. STREET ADDRESS (If rural, give location) 122 W 3rd St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Aug 17 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Pennsylvania | USA. |

13. FATHER'S NAME John Brown

14. MOTHER'S MAIDEN NAME Mary Dempsey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Norman Brown | 122 W 3rd Oxford Pa. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arteriosclerotic Heart Disease | 10 yrs. |
| DUE TO | | |
| (B) | Diabetes mellitus. | 15 yrs. |
| DUE TO | | |
| (C) | Gangrene, r. foot. | 7 days. |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-14-49 | Gangrene, r foot due to arteriosclerosis | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 10, 1949 *to* Oct 14, 1949 *that I last saw the deceased alive on* Oct 14 1949, *and that death occurred at* 12:30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Norman Brown M. D. | Union Memorial Hospital | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 17-49 | Oxford | Oxford Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 VS 103. | Huntington Williams M.D. | J. E. Tyson Risinger | Oxford Md |

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G78953

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78953

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Dietz.

2. DATE OF DEATH: Oct. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1400 N. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aged Women's and Aged Men's Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1400 N. Lexington 19-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Aug. 2, 1861 | 88 | 2 | 11 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farming | | Maryland | |

13. FATHER'S NAME: Philip Dietz

14. MOTHER'S MAIDEN NAME: Catharine Brandow

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | L. A. Read | 1400 N. Lexington Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerotic Cardio-vascular disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from February, 1949, to October 13, 1949, that I last saw the deceased alive on October 11, 1949, and that death occurred at 3:00 p. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Neuland Edward Day M. D. | 4-E-33rd St - 18 | October 14, 1949 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~or CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/15/49 | Mt. Olive | R.F.D. 3 Balto. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 127 St. Paul St. |

VS 150

46E

G78954

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78954

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) FRANCIS LEONARD

2. DATE OF DEATH October 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1605 St. Paul Street 12-05

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | 3/2/1918 | 31 | 7 / 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sign Painter | Read Drug Co. | Balto. Md. | |

13. FATHER'S NAME: Edward Leonard

14. MOTHER'S MAIDEN NAME: Vessie Lawrence

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 219-01-4328 | Thelma B. Leonard 1605 St. Paul St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | October 14, 1949 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | Wm Cook Inc. 1217 St. Paul St. |

VS 151

13B

C78955

BIRTH NO. 48-06411

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C78955

1. NAME OF DECEASED (Type or Print) William J Wagener Jr.

2. DATE OF DEATH 10-14-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hosp

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3315 Washington Blvd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 3/17/48 | 1 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME William J. Wagener Sr.
14. MOTHER'S MAIDEN NAME Florine M. Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.

17. INFORMANT Mr William J Wagener Sr ADDRESS 3315 Wash Blvd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Operative procedure — Repair of cleft palate.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 10-14-49
19B. MAJOR FINDINGS OF OPERATION Cleft Palate
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-12, 1949 *to* 10-14, 1949, *that I last saw the deceased alive on* 10-14, 1949, *and that death occurred at* 1:00 P *m., from the causes and on the date stated above.*

23A. SIGNATURE William M. Bird M.D.
23B. ADDRESS WBGH.
23C. DATE SIGNED 10-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/17/49
24C. NAME OF CEMETERY OR CREMATORY Woodbridge Mem. Pk.
24D. LOCATION (City, town, or county) (State) Washington Rd. Lorsor Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR James J. Lowman & Son ADDRESS 1579 Pratt St.

VS 150

G789.56

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

541 1

Registered No. G789.56

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Malcolm B. Martin

2. DATE OF DEATH: Oct. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4747 Park Heights Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4747 Park Heights Ave. 7-7-16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Feb. 19, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| guard | Bendix Corp. | Baltimore, Md. | U. S. |

13. FATHER'S NAME: Thomas B. Martin

14. MOTHER'S MAIDEN NAME: Lillian C. Pendleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Annie E. Martin — ADDRESS: 4747 Park Heights Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Operations for hernia, rt; gastro-enterostomy & vagotomy — INTERVAL BETWEEN ONSET AND DEATH: 9/7/49

DUE TO

(B) Multiple emboli — 10/12/49

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/7 & 9/27/49 | Old adherent band down large duodenal ulcer | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/1, 1949, *to* 10/12, 1949, *that I last saw the deceased alive on* 10/12, 1949, *and that death occurred at* 11:[illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Morrison M. D. | 11 E. Chase St., Baltimore | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/15/49 | Cedar Hill | Brooklyn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | John O. Mitchell & Sons, Inc. | 1900 Eutaw Pl. |

Mackson B. Mitchell

VS 150

117B

G78957

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78957

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Curran Schuncke

2. DATE OF DEATH: October 13, 1949

3. PLACE OF DEATH: Baltimore City, Maryland — 627 E. 33rd St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 627 E. 33rd St. — 9-05

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: August 3, 1871
9. AGE (In years last birthday): 78 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pittsburgh, Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Peter Curran
14. MOTHER'S MAIDEN NAME: Carrie ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: William H. Schuncke - 627 E. 33rd St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) DUE TO | Hypertensive Arteriosclerotic Cardiovascular Disease | 15 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Diabetes Mellitus, Mild | 20 yrs. |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 19[illegible], *to* Oct. 13, 1949 *that I last saw the deceased alive on* 11 Oct., 1949, *and that death occurred at* 9:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M. D.
23B. ADDRESS: 5015 Sheridan Ave.
23C. DATE SIGNED: Oct. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 10/17/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 15 1949
REGISTRAR'S SIGNATURE: Curtis Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl.
Madison B. Mitchell

VS 150

61

G789.58

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G789.58

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDGAR REECHER

2. DATE OF DEATH: October 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2834 Oakley Avenue 22-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 7-27-1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Life Insurance | Bengold - Md | U.S. |

13. FATHER'S NAME: William C. Reecher

14. MOTHER'S MAIDEN NAME: Mollie Pryor

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 207-01-4116 | Lillian M. Reecher | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Russell S Fisher M.D. | | 10-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 19-1949 | Green Hill | Waynesboro Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | H. D. Earnshaw | Hyattsville, Md |

VS 151

94a

Correct age is especially important. If uncertain, please write the cause of death clearly and legibly.

G78959

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

163 Registered No. G78959

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Johnson

2. DATE OF DEATH: October 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 403 N. Vincent St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 403 N. Vincent St. 19-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Single | Nov. 3, 1885 | 63 | 11 | 10 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Race Horse Trainer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Horace Johnson

14. MOTHER'S MAIDEN NAME: Susie Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rebecca Washington ADDRESS: 403 N. Vincent St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lung Tumor

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Unknown

over

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 5, 1949, *to* Oct. 13, 1949, *that I last saw the deceased alive on* Oct. 12, 1949, *and that death occurred at* 9:45 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard H. Hunt M. D.

23B. ADDRESS: 1631 W. Franklin St. 23

23C. DATE SIGNED: 10-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10-16-49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 14 1949

REGISTRAR'S SIGNATURE: Lester Williams, MD

25. FUNERAL DIRECTOR: Mrs. Kortin R. Williams ADDRESS: 324 N. Schroeder St.

VS 150

47D

G78960

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78960

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RUTH V. WALLER

2. DATE OF DEATH: Oct. 13, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2122 Mt. Holly St.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2122 Mt. Holly St.

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Sept. 6, 1896 | 53 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Railroad | Sharptown, Md. | |

13. FATHER'S NAME: Richard Waller

14. MOTHER'S MAIDEN NAME: Ellen J. Rider

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mrs. J. W. Sindall | 3005 Windsor Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Amyotrophic Lateral Sclerosis | about 3 yrs. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypo-static pneumonia | 1 day |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* June 1949 *to* Oct 13, 1949, *that I last saw the deceased alive on* Oct 13, 1949, *and that death occurred at* 9.38 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wallis Stubbs M. D. | 2220 Garrison Blvd | Oct 14 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Taylor's Methodist Cem. | Sharptown, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

82

G789:1

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

80

G789:1

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): John L. Etter

2. DATE OF DEATH: October 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 404 Allegheny Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Oct. 15, 1895 | 53 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Teacher | Balto. Co. Dept. Edu | Maryland | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel FreyEtter | Cecilia Erdman. |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mr. Walter T. Maguire | 3607 Pleateau Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Adenocarcinoma of right Kidney — 3 years.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 2, 1949 | Carcinoma, metastatic, involving thoracic vertebra #8 | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 24, 1949, *to* Oct. 14, 1949, *that I last saw the deceased alive on* Oct. 14, 1949, *and that death occurred at* 9:50 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis H. Watt M. D. | Union Memorial Hosp. | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Friends Burial Ground | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

52a

G78962

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78962 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Francis Flynn Jr

2. DATE OF DEATH: 10/14/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 13 E. Oostend St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE 13 B. COUNTY E. Oostend

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md

D. STREET ADDRESS (If rural, give location): 13 E. Oostend St 23 or

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | Married | 2 1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Post Office | U. S. Gov. | Baltimore Md | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John F. Flynn Sr | Rose McCall |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs J. F. Flynn Jr | 13 E Oostend |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs?

DUE TO

(B) Cardiac Hypertrophy

DUE TO

(C) Cardiac Dilatation

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* Oct 14, 1949 *that I last saw the deceased alive on* Oct 14, 1949, *and that death occurred at* 12A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Vincent M Mesaros M. D. | 1403 S Charles St | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Cathedral | Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | J. J. Raley & Sons | 1318 Eutaw St |

VS 150

95c

G78963

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 156402

STATE NO. 49-25015

1. NAME OF DECEASED (Type or Print) DORIS. WOODS

2. DATE OF DEATH 10-14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ellicott City

c. Length of stay in Baltimore ~~Yrs~~ 2 ~~Mos. Days~~

D. STREET ADDRESS (If rural, give location) Johnny Cake Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | single | 11-17-1948 | 10 | 11 / 27 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | None | Maryland | U.S.A. |

13. FATHER'S NAME Glaves Woods

14. MOTHER'S MAIDEN NAME DORIS. JENKINS

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Mr. Glaves Woods | Ellicott City Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | TUBERCULOUS MENINGITIS | |
| DUE TO | | |
| (B) | BILATERAL APICAL TUBERCULOSIS | |
| DUE TO | | |
| (C) | | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/20/, 1949 *to* 10/17/, 1949 *that I last saw the deceased alive on* 10/13/, 1949, *and that death occurred at* 2:15 *p. m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas. F. Sloan M. D. | 16. Ogden Way. | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 16, 1949. | Good Shepherd Cemetery | Ellicott City. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams M.D. | Easton Sons | Ellicott City, Md. |

VS 150

12B

G7896-4 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1949 — Registered No. G7896-5

1. NAME OF DECEASED (Type or Print): Mergit Rochmes

2. DATE OF DEATH: Oct 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Vienna
B. COUNTY: Austria
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): (visiting) Baltimore
D STREET ADDRESS (If rural, give location): 1402 E Fort Ave 7-4-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Apr 17, 1917 | 32 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Vienna, Austria | Austria |

13. FATHER'S NAME: Ludwig Jawor

14. MOTHER'S MAIDEN NAME: Marie Tiller

| *15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma (Lymphosarcoma) Disseminated.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(INTERVAL BETWEEN ONSET AND DEATH)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 16, 1949, *to* Oct 14, 1949, *that I last saw the deceased alive on* Oct 14, 1949, *and that death occurred at* 1125 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Union Memorial Hospital | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-17-49 | Holy Cross | R. R. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | Charles F. Dill | |

VS 150

55E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78965

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G78965

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carrie B. Gunkel

2. DATE OF DEATH: Oct. 14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1414 Marshall St.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 1414 Marshall St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Feb. 8-1863 | 76 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Balto. Md | U.S.A. |

13. FATHER'S NAME: John Edwards

14. MOTHER'S MAIDEN NAME: Lena Baker

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Robert Moon | 1414 Marshall St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Generalized Arteriosclerosis — 2 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 1948 *to* Oct 14, 1949 *that I last saw the deceased alive on* Oct 14, 1949 *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1400 Annapolis | 10/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-17-1949 | Baltimore | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | [signature] | Flynn & Fleming | 1426 Light St. |

VS 150

94a

Correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G7896 — G7896

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4201

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY A. GIESE

2. DATE OF DEATH: OCT. 12, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 701 S. BAYLIS ST.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 701 S. BAYLIS ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | WIDOWED | DEC. 20, 1872 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED | SEAMSTRESS | BALTIMORE, MD. | U.S.A. |

13. FATHER'S NAME: JOHN BELLEBAUM

14. MOTHER'S MAIDEN NAME: ? WOELFER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.

17. INFORMANT: EMIL GIESE — ADDRESS: 516 N. DECKER AV.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis
DUE TO
(B) Coronary Artery Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 6, 1947 *to* OCT 12, 1949 *that I last saw the deceased alive on* March 26 1949, *and that death occurred at* 10:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward A. Flanigan Jr. M. D. | 3503 Fait Ave | 10-14-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-15-49 | SACRED HEART CEM. | GERMAN HILL RD. BALTO. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 15 1949 | Huntington Williams, M.D. | Charles S. Zeiler | 901 So. Conkling St. |

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M M 37285 17 ✓ G78967

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

16 ✓ Registered No.

1. NAME OF DECEASED (Type or Print): PHILIP William, Strassberger

2. DATE OF DEATH: 10-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1155 Carroll ST. Z 30 2-07

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July ?, 1882
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 218-05-9647
17. INFORMANT: B.C.H. Records ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchiogenic Carcinoma
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic Heart Disease.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-13- , 1949 *to* 10-14- , 1949, *that I last saw the deceased alive on* 10-14- 1949 *and that death occurred at* 12.40 PM, *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Logan M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 10-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 10/18/49
24C. NAME OF CEMETERY OR CREMATORY: ~~St Peters Cem~~ Oak Lawn Cemetary
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas P. Towell
ADDRESS: 2427 Edmondson Ave

22482

47C

G78968

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 174

G78968

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MARY HELEN PEACOCK

2. DATE OF DEATH Oct. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2619 HAFER Street.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-04

D. STREET ADDRESS (If rural, give location) 2619 HAFER STREET

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | White | MARRIED | DEC. 3, 1900 | 48 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | HOME | MARYLAND | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Vogelsang | MOLLIE ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | NONE | NONE | Roland B. Peacock | 2619 HAFER St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH: 12 MO

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* Oct 15, 1949, *that I last saw the deceased alive on* Oct 15, 1949, *and that death occurred at* 9:00A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward J. Kalleins M. D. | 1897 W. North Ave | 10/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 17, 1949 | Mt. Olivet | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | George L. Schwab | 2101 Frederick Ave. |

VS 150

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G78[illegible] (2) G78[illegible]

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Wolfe (Mary Regina Wolfe)

2. DATE OF DEATH: 10-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 32 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 800 McCabe Avenue 2 7 10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Aug. 17, 1917 | 32 | 1 | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Food Packer | Food Packer | Md | U.S.A. |

13. FATHER'S NAME: Charles T. Wolfe

14. MOTHER'S MAIDEN NAME: Margaret Whalen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 216-12-7917

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Amyloidosis -due to Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-11-44 4-18-47 | Pulmonary Tuberculosis-Empyema | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 8-8, 1944, *to* 10-13, 1949 *that I last saw the deceased alive on* 10-13, 1949, *and that death occurred at* 12:50 P *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. L. Rogers M. D. | 4940 EASTERN AVENUE | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-17-49 | New Cathedral Cemetery | Edmondson Ave, Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 16 1949 | Evelyn Williams, M.D. | George J. Ruth, Inc. 1735 Harford Ave. |

VS 150

130

Correct age in expectant mothers. Physicians: please write the causes of death clearly and legibly.

(4). G78970 ✓ G78970

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Philip J.Krastel

2. DATE OF DEATH: IO-I5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Pauls Church I440 N.Caroline Street
C. Length of stay in Baltimore: 50 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,Md.
D. STREET ADDRESS (If rural, give location): I738 E.Federal Street 8 06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | IO-I8-I868 | 80 | II | 27 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sexton | Church | Baltimore County Md. | U.S.A. |

13. FATHER'S NAME: Joseph Krastel

14. MOTHER'S MAIDEN NAME: Catherine Bunn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Mr.Joseph P.Krastel | I738 E.Federal St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

DUE TO

(B) Arteriosclerosis — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan. 10, 1947, *to* Oct. 15, 1949, *that I last saw the deceased alive on* Oct. 15, 1949, *and that death occurred at* 11:30 A. m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph Levi, M.D. | 1005 N. Broadway-13 | 10/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | IO-I8-49 | Most Holy Redeemer | Belair Road,Balto;Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 18 1949 | Evelyn Jones Williams M.D. | George J.Ruth,Inc. I735 Harford Ave. |

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G78971

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78971

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leon M Blackman

2. DATE OF DEATH: 10/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newport News Va
D. STREET ADDRESS (If rural, give location): 5114 Huntington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | | 58 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | | Russia | |

13. FATHER'S NAME: Harry

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Sarah Blackman | Newport News Va |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. J. Turbowski M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 10/16/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10-16-49 | | Newport News Va |

DATE RECEIVED BY LOCAL REGISTRAR: Oct 17 1949

REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc

ADDRESS: 2100 Eutaw Pl

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78972 G78972

BALTIMORE CITY HEALTH DEPARTMENT 31

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM C. NUTTER

2. DATE OF DEATH: 10/14/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 821 N. Luzerne Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL and give township)
D STREET ADDRESS (If rural, give location) 821 N. Luzerne Ave. 7-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | May 6, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| INSPECTOR | National Can Co. | Somerset County, Md. | U.S. |

13. FATHER'S NAME: William T. Nutter

14. MOTHER'S MAIDEN NAME: Kate McDaniel

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | | Mrs. Vida Nutter, 821 N. Luzerne Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 1 week. |
| DUE TO | arteriosclerosis - generalized | ? |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan, 1936 *to* Oct 14, 1949 *that I last saw the deceased alive on* Oct 12 1949 *and that death occurred at* 12 noon *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis T. Kleinert M. D. | 2623 E. Monument St | 10/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Junior Cemetery | Oriole, Maryland. (Somerset Co) |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 16 1949 | Lucinda Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 50

83a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. G78973

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 1 G78973

1. NAME OF DECEASED (Type or Print): Stanley Joseph Hubata

2. DATE OF DEATH: Oct. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1403 Dundalk Ave.
C. Length of stay in Baltimore: 57 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 1403 Dundalk Ave. 76-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | Jan. 26, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Motor Car Operator | Bethlehem Steel Corp | Czechoslovakia | U. S. |

13. FATHER'S NAME: Joseph Hubata

14. MOTHER'S MAIDEN NAME: Katherine Plasil

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Antonia Hubata, 1403 Dundalk Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Artery Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Russell S Fisher M.D. | | Oct. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/49 | Holy Redeemer Cem. | 4430 Belair Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 16 1949 | Lucille Lee Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

G78974 ✓ G78974

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ANNA DUVALL

2. DATE OF DEATH 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) FRANKLIN Square Hospital

c. Length of stay in Baltimore 34 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-04
D. STREET ADDRESS (If rural, give location) 1512 HENRY Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Married | Sept. 8-1885 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel Cohalan

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT William L. Duvall ADDRESS 1512 Henry St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(B) Cerebral arteriosclerosis — 25 years
DUE TO
(C) Hypertensive Cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 1949, *to* 10-15, 1949, *that I last saw the deceased alive on* 10-15, 1949, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE George W. Babcock M. D.
23B. ADDRESS Franklin Sq. Hosp.
23C. DATE SIGNED 10-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 19 1949
24C. NAME OF CEMETERY OR CREMATORY Holy Cross
24D. LOCATION (City, town, or county) (State) A. A. Co.

DATE RECEIVED BY LOCAL REGISTRAR OCT 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR A. Howard Ellenson
ADDRESS 1400 Edmondson Ave

VS 150

927

G78975

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

570.1 G78975

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catharine A. Preston

2. DATE OF DEATH: 10-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balt Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto — 19-03
D. STREET ADDRESS (If rural, give location): 431 S. Gilmor St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | 3/31/1862 | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Maryland | U.S.A. |

13. FATHER'S NAME: James Carney

14. MOTHER'S MAIDEN NAME: Catherine Mattingly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | None | Helen Proctor | 431 S. Gilmor St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Paralytic ileus

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Arteriosclerotic Cardiovascular disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-13-49 | Intestinal obst. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-13-49 19__, *to* 10-14-49 19__, *that I last saw the deceased alive on* 10-14-49, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard Raskin M. D. | Mercy Hospital | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/49 | New Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | John A. & B. M. Wallace | Stockton |

VS 150

122 B

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

G789/6

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 8 v. 4 G789/6

Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA LEISH N-864.4

2. DATE OF DEATH: October 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2805 Sante Fe Avenue 15 13

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1903
9. AGE (In years last birthday): 46 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Getzel Freeman
14. MOTHER'S MAIDEN NAME: Mary Arnest
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frank Leish ADDRESS: 2805 Sante Fe Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive abdominal hemorrhage, due to rupture of liver.
DUE TO
(B) Fractures of ribs, humerus, radius, ulna, tibia, and fibula.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Reisterstown Road, 100' porth of Quantico Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 14, 1949 5:45 P.M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR?: Pedestrian struck by auto 15/13

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 10-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-17-49
24C. NAME OF CEMETERY OR CREMATORY: Herring Bnai Jacob Cong. Ryh
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North Ave

VS 151

170c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G789.17 CERTIFICATE CORRECTED 10-24-49 X ✓ G789.17

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1949-B

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John B. DILWORTH JR. 2. DATE OF DEATH 10/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Life 32 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Co. Govans
D. STREET ADDRESS (If rural, give location) 1211 Overbrook Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Oct 7 1917 | 32 | | 7 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor Foreman
10B. KIND OF BUSINESS OR INDUSTRY Harry T. Campbell
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John B. DILWORTH
14. MOTHER'S MAIDEN NAME Mary E. MONMONIER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 214-18-5241
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma primary site not determined | 3 months |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) Pulmonary congestion & Edema | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Paralytic ileus | |

19A. DATE OF OPERATION 19B. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/14 , 1949, to 10/14 , 1949, *that I last saw the deceased alive on* 10/14 , 1949, *and that death occurred at* 9:35 P *m., from the causes and on the date stated above.*

23A. SIGNATURE E. Richard Frank M. D. 23B. ADDRESS Mercy Hospital 23C. DATE SIGNED 10/14/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/17/49 | St. Stephens | Baltimore County, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Leander Funeral Home | 7401 Belair Rd. |

VS 150

55E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

6789/8 6789/8

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4v° 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LAURA D. FORSYTHE

2. DATE OF DEATH Oct. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3522 6th Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-04
D. STREET ADDRESS (If rural, give location) 3811 5th Street, Brooklyn, Baltimore, Md.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 22, 1879
9. AGE (In years last birthday): 70 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Gideon Conner
14. MOTHER'S MAIDEN NAME: Elizabeth D. Pusey
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ethel Essex, ADDRESS: 3522 6th St., Brooklyn, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary disease of heart — INTERVAL BETWEEN ONSET AND DEATH: 7 weeks.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardio vascular disease. — ?

DUE TO

(C) Chronic arthritis. — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: - - -
19B. MAJOR FINDINGS OF OPERATION: - - -
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): - - -
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): - - - -
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 26, 1949, *to* Oct. 15, 1949 *that I last saw the deceased alive on* 10/13/ 1949, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Weisel, M. D.
23B. ADDRESS: 1226 Hanover St.
23C. DATE SIGNED: 10/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/18/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Thurston for Williams, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., ADDRESS: 1217 St. Paul St.

VS 150

93c

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G7897.9 G7897.9

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153 Registered No.

1. NAME OF DECEASED (Type or Print): Carl W Diemling (DEIMLING)
2. DATE OF DEATH: 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1632 John St 14-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 19 1897
9. AGE (In years last birthday): 52
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Walter S Crowe
11. BIRTHPLACE (State or foreign country): New York N.Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chas J Diemling
14. MOTHER'S MAIDEN NAME: Elizabeth Leip

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Ruth Diemling. ADDRESS: 1632 John St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon
DUE TO
(B) & Metastasis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 mo.

19A. DATE OF OPERATION: Sept. 49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Colon & metastasis
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-26, 1949 *to* 10-15, 1949, *that I last saw the deceased alive on* 10-15, 1949, *and that death occurred at* 10:58 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William W. Bindeman M.D.
23B. ADDRESS: WBGH
23C. DATE SIGNED: 10-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/19/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm C Fox Inc. ADDRESS: 1219 E Fayette St

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VV 73

46E

678980

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 3 30 Registered No. 678980

1. NAME OF DECEASED (Type or Print): LOUISE LEWIS
2. DATE OF DEATH: 10/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-17
D. STREET ADDRESS (If rural, give location): 3105 Rodgers Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 3/9/78 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Keeper | Private Home | England | |

13. FATHER'S NAME: (Unknown) Lewis
14. MOTHER'S MAIDEN NAME: Anna Louise (Unknown)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|
| No | |

17. INFORMANT: Mrs Harry Lewy ADDRESS: 5510 Pimlico Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertension
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/3, 19 49, *to* 10/15, 19 49, *that I last saw the deceased alive on* 10/15 19 49 *and that death occurred at* 4 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Blaylock M.D. | Maryland General | 10/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Druid Ridge | Pikesville Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 217 S. Fund St.

VS 150 5006.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

G78931 — BALTIMORE CITY HEALTH DEPARTMENT — G78931

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Charles A. Harrell
2. DATE OF DEATH: 10/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3811 St. Margaret St. Brooklyn
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3811 St. Margaret St. 25-05

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 24th 1900
9. AGE (In years last birthday): 44 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shop Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Rivets Copper & Brass
11. BIRTHPLACE (State or foreign country): Blacksburg Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Harrell
14. MOTHER'S MAIDEN NAME: Alma Harrell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W. W. #1
16. SOCIAL SECURITY NO:
17. INFORMANT: Maude Harrell — ADDRESS: 3811 St. Margaret St. Brooklyn

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized arteriolar sclerosis | 1½ yrs |
| DUE TO (B) | Diabetes Mellitus | 2 years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1947, *to* Oct 14 1949, *that I last saw the deceased alive on* Oct 12 1949, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul Schofield M. D.
23B. ADDRESS: 730 Annapolis Rd
23C. DATE SIGNED: 10/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/17/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 150 216 31

61

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G78982

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

5-7.1 G78982

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): George A. Howell

2. DATE OF DEATH: Oct. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1741 E. 25th. St.
C. Length of stay in Baltimore: 59 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1741 East 25th. St. 805

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | April 25, 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Crane Opertor | Ship Const. | Plymouth, Penn. | U. S. A. |

13. FATHER'S NAME: William H. Howell

14. MOTHER'S MAIDEN NAME: Mary Hopkins

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mary A. Howell | 1741 E. 25th. St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | myocardial failure | 3 days |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | Pulmonary Emphysema | 5 years |
| (C) DUE TO | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 1946 *to* Oct. 1949, *that I last saw the deceased alive on* Oct. 13, 1949, *and that death occurred at* 8:40 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clarence W. LeDoux M. D. | 3023 Eastern Ave | 10/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 17, 49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Chas. J. Evans & Son Inc. | 118 W. Mount Royal Ave. |

VS 150

35 F 4V

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ES-132486

G78983

BIRTH NO. 49-19604

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

571 G78983 Registered No.

1. NAME OF DECEASED (Type or Print): Olan Jones

2. DATE OF DEATH: 10-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
c. Length of stay in Baltimore: 6 Weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1320 Harlem Avenue 16.02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Single | August 28, 1949 | | 1 | 16 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wadell Massey
14. MOTHER'S MAIDEN NAME: Doris Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diarrhoea
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10 19 49 *to* 10-14 19 49 *that I last saw the deceased alive on* 10-14 19 49 *and that death occurred at* 7:40 P. M. *from the causes and on the date stated above.*

23A. SIGNATURE: C. A. Rogers M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED: 10-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-17-49
24C. NAME OF CEMETERY OR CREMATORY: mt auburn
24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Jr.
25. FUNERAL DIRECTOR: George G. Nelson ADDRESS: 1303 Pennsylvania ave

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

119a

G78984

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78984

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William T. Campbell

2. DATE OF DEATH: October 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1802 N. Monroe St.
c. Length of stay in Baltimore: 30 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1802 N. Monroe St

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb 8, 1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter
10B. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: London Campbell
14. MOTHER'S MAIDEN NAME: Mary Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mildred Hatcher ADDRESS: 554 Baker St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) arterio-sclerotic cardiac disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: unk.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8.23 1949 *to* 10.14, 1949 *that I last saw the deceased alive on* 10/12, 1949 *and that death occurred at* 5-30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature]
23B. ADDRESS: RAYNER HOPE, M.D. 1300 EAST MADISON ST. BALTIMORE 2, MD.
23C. DATE SIGNED: 10.15.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-18-49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus
24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George S. Kelson ADDRESS: 1303 Presstman st

VS 150 JFW 71

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78985

G78985

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

19 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Wodka

2. DATE OF DEATH: Oct, 14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2106 Fleet Street
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home
C. Length of stay in Baltimore: 37 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore-31
D. STREET ADDRESS (If rural, give location): 2106 Fleet Street 1-04

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 25-1888
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 61

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoremen
10B. KIND OF BUSINESS OR INDUSTRY: Stevedore
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wodka
14. MOTHER'S MAIDEN NAME: Maryanna Stysch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 215-09-3361
17. INFORMANT: Anna Wodka 2106 Fleet street ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(B) Carcinoma of Urinary Bladder — 1 yr
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 12 49, to Oct 14 49, *that I last saw the deceased alive on* Oct 12 19 49, *and that death occurred at* 7:35 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William J. Bauer M. D.
23B. ADDRESS: 801 W Lexington St
23C. DATE SIGNED: 10/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct, 18-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M
25. FUNERAL DIRECTOR: George A. Weber ADDRESS: 705 South Ann Street

VS 150

90651

George A Weber 52R

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78986 X ✓ 43 G78986

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Albert C. Rucker

2. DATE OF DEATH 10/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glen Burnie
D. STREET ADDRESS (If rural, give location) 1030 Thomas Road

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Jan. 13, 1881
9. AGE (In years last birthday) 68 If Under 1 Year: Months, Days If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cotton Broker
10B. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Houston Rucker
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Franklin Sq. Hos. Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Hypertensive Cardio Vascular Disease

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE J. M. R. Samuels M. D.
23B. ADDRESS 7 E. Lexington
23C. DATE SIGNED 10/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/17/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Hayes
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR John O. Mitchell & Sons ADDRESS 1900 Eutaw Place

VS 150

1560 937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78987

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78987

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Caesar Taylor

2. DATE OF DEATH: Oct. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore ~~Patapsco Neck~~
D. STREET ADDRESS (If rural, give location): 238 Elizabeth Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | | 3-16-78 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ~~None~~ | | West Indies | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ~~Robert~~ Taylor | Ada Scott |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/28, 1949 *to* 10/15, 1949, *that I last saw the deceased alive on* 10/15, 1949, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip D. Wagley M. D. | JOHNS HOPKINS HOSPITAL | 10-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/49 | Mt. Calvary | A. A. Co., Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | L. L. Brown & Son | 1020 Montgomery St |

VS 150

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G78988

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 44

G78988

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sophia MARGARETTA RIDGELY

2. DATE OF DEATH Oct 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO GEN HOSP

C. Length of stay in Baltimore 50 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2019 Maryland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | Single | May 2 1869 | 80 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Missionary | | Balto. Co Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Ridgley | Margaretta Sophia Howard |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Eliza Ridgley | 2019 Md. Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO. VASCULAR ACCIDENT

DUE TO

(B) HYPERTENSIVE ARTERIOSCLEROTIC CVD

DUE TO

(C) HYPERTENSIVE ICIDNEY

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/1 19 49 *to* 10/14/49 *that I last saw the deceased alive on* 10/13 19 49 *and that death occurred at* 2:10 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jos Gromley M. D. | W Balto | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | "Hampton" | Towson Balto Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Henry Wenkins Sons Co | 4905 York Rd. |

VS 150

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937

G78989

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50 Registered No. G78989

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANCIS X. FARNAN

2. DATE OF DEATH: OCT. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5230 YORK RD.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 5230 YORK RD. 22-11

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: DEC. 23, 1876
9. AGE (In years last birthday): 72
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUSINESS EXECUTIVE
10B. KIND OF BUSINESS OR INDUSTRY: AUTOMOTIVE
11. BIRTHPLACE (State or foreign country): BALTO.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: JAMES I. FARNAN
14. MOTHER'S MAIDEN NAME: SARAH JENKINS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: WALTER LAWRENCE ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma, esophagus — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 7 SEPT. 1949
19B. MAJOR FINDINGS OF OPERATION: Complete obstruction, esophagus, due carcinoma
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1949, *to* OCT. 15, 1949, *that I last saw the deceased alive on* OCT. 15, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. H. Kammer Jr. M. D.
23B. ADDRESS: 501 Sheridan Ave.
23C. DATE SIGNED: Oct 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): ENTOMBMENT
24B. DATE: 10-18-1949
24C. NAME OF CEMETERY OR CREMATORY: LORRAINE PARK
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO. ADDRESS: 4905 YORK RD.

VS 150

46a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78990 X ✓ 523.0 G78990

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert J. Rumney

2. DATE OF DEATH: 10/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen. Hosp.
c. Length of stay in Baltimore: Yrs. ___ Mos. ___ Days ___

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: A. A. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garland Park
D. STREET ADDRESS (If rural, give location): 103 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Oct. 28, 1883 | 65 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Iron Mounder (rtd) | U. S. Navy Yard | Baltimore, Md. | |

13. FATHER'S NAME: Millard F. Rumney

14. MOTHER'S MAIDEN NAME: Elizabeth Wilkerson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | none | Mrs. Albirta L. Rumney 103 Linden Ave., Garland Pk., Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cor Pulmonale, Chronic | unknown |
| DUE TO (B) | Silicosis | Unk. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Neoplasm, Kidney, (malignant) | Unknown |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 8, 1949 *to* Oct 15, 1949 *that I last saw the deceased alive on* Oct 15, 1949, *and that death occurred at* 5:44 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jos Shear M. D. | WBGH. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/49 | Cathedral Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

52a

Please write clearly with unfading ink. Every item of information should be given if correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78991

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 no. 1 G78991 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HOWARD MONROE JEFFERSON

2. DATE OF DEATH: 10/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4515 Northwood Drive
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4515 Northwood Drive 27-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 2, 1884 | 64 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| salesman | Retail Men's Haberdashery | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert T. Jefferson | Laura Monroe |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | 212-05-3688 | Mrs. Mary G. Jefferson-4515 Northwood/ Drive |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CORONARY Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* DEPT, 19 49, *to* ____, 19 ____, *that I last saw the deceased alive on* Oct 10 19 49 *and that death occurred at* 1:15 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter E. Rayson M. D. | 4331 Harford Rd | 10/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/19/49 | Parkwood Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

248 65

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78992

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78992 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN EDWARD DIENSTBACH

2. DATE OF DEATH: Oct. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5400 Lothian Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5400 Lothian Rd. 2-7-48

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | Jan. 22, 1874 | 75 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): collector
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Philip Dienstbach
14. MOTHER'S MAIDEN NAME: Mary May
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): none (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Miss Emma B. Dienstbach ADDRESS: 5400 Lothian Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Ht Dis. | 10 yrs? |
| DUE TO (B) | Arteriosclerosis | 20 yrs? |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypostatic Pneumonia and Malnutrition | 5 days & 6 mos |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 11, 1949 *to* Oct 15, 1949, *that I last saw the deceased alive on* Oct 11, 1949, *and that death occurred at* 7 4 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jonas Cohen M. D.
23B. ADDRESS: ~~5400 Lothian~~ 5901 Park Heights Ave
23C. DATE SIGNED: 10/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/18/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

78993

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

63 Registered No. G78993

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Geo.F.C.Ochse

2. DATE OF DEATH: Oct.15,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3509 Woodlea Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3509 Woodlea Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md.
D. STREET ADDRESS (If rural, give location): 3509 Woodlea Ave. 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Dec.14,1878 | 70 71 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Handy Man | B & O R.R. | Baltimore | |

13. FATHER'S NAME: Frederick Ochse

14. MOTHER'S MAIDEN NAME: Mary Dukenburg

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| -- | --- | 213-01-5222 | Mrs.Lillian Ciscle | 3509 Woodlea Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Ca of the Lung. | 1 mo |
| DUE TO (B) | Hypertensive Cardio | 1 mo |
| DUE TO (C) | Vascular Lesion. | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 11 '49 *to* Oct 15 '49, *that I last saw the deceased alive on* Oct 17, 1949, *and that death occurred at* 3 44 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Fred Muzzy M. D. | 5001 Belvedere Park Rd | 10-17 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct.18/49 | Loudon Park Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Philip Hennig Son | 2024 Orleans St. |

VS 150

496 47

47D

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

67894 JL- 132325

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

430.0 67894 Registered No.

1. NAME OF DECEASED (Type or Print): John Lyles

2. DATE OF DEATH: 10-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 9 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 608 Roundview Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | ? | Aug. ? 1919 ? | 30 ? | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Md. Ship yard
11. BIRTHPLACE (State or foreign country): S. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: James Lyles
14. MOTHER'S MAIDEN NAME: Carrie Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 230-10-5931
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Acute bacterial endocarditis | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 3, 19 49 *to* Oct. 10, 19 49 *that I last saw the deceased alive on* Oct. 10, 19 49 *and that death occurred at* 1.15 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Ave. | 10-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/15/49 | St. Johns Church Cem. | Dewberry S. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Robert F. Williams | 1515 McElderry St |

VS 150

988.40 91a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly. ALL WRITING MUST BE WITH UNFADING INK. Every item of information should be carefully supplied.

G78995

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

G78995 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Daisy Sneed

2. DATE OF DEATH: Oct. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident
C. Length of stay in Baltimore: 35 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1407 Argyle Ave. 14-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | married | Dec. 10 1906 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Greensborough, N.C. | U.S.A. |

13. FATHER'S NAME: John Cooper

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or title of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Robert Sneed | 1407 Argyle Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | ☒ | Oct. 14 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 16, 1949 | Arbutus Mem. Pk. | Balt. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Holland Funeral Home | 937 W. Druid Hill Ave. |

VS 151

Please WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G78996

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

57 0 3 G78996 Registered No.

MS—127945 BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosa Matthews

2. DATE OF DEATH: 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3520 N. Hilton Rd. 15-11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 3, 1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: William Bowie

14. MOTHER'S MAIDEN NAME: Sarah Atwell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Records-- | Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bowel Obstruction — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Volvulus Sigmoid Colon

DUE TO

(C) Pulmonary Edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-14-49 | Int. obstruction | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4-1- , 1949, *to* 10-15- , 1949 *that I last saw the deceased alive on* 10-15 , 1949, *and that death occurred at* 1:00 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rogers M. D. | Baltimore City Hospitals | 10-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 19/49 | Maryland Mem | Balto Co |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Ulland Funeral Home | 2008 Aliceanna |

VS 150

122 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78997

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G78997

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Ament, Lawrence Wesley**

2. DATE OF DEATH **Oct 15, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **U. S. Marine Hospital**

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **619 N. Castle St.** 7-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 25, 1895 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Plasterer**

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Maryland**

12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **George W. Ament**

14. MOTHER'S MAIDEN NAME **Annie Naylor**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) **Yes** (If yes, give war or dates of service) **WW I**

16. SOCIAL SECURITY NO **unk**

17. INFORMANT **same as above** ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **carcinoma of lung, metastatic to regional lymph nodes, skin of neck, adrenals, and kidney.**

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: **7½ mo.**

19A. DATE OF OPERATION **May 17, 1949**

19B. MAJOR FINDINGS OF OPERATION **Exploratory thoracotomy, right. Carcinoma of rt. lung**

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **18 April** 19**49** *to* **15 Oct** 19**49**, *that I last saw the deceased alive on* **15 Oct** 19**49**, *and that death occurred at* **10:52** p.m., *from the causes and on the date stated above.*

23A. SIGNATURE **Andrew G. Morrow** M. D.

23B. ADDRESS **U.S. Marine Hospital**

23C. DATE SIGNED **Oct 16, 1949**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Buried**

24B. DATE **Oct 19/49**

24C. NAME OF CEMETERY OR CREMATORY **Parkwood**

24D. LOCATION (City, town, or county) (State) **Balto Co Md**

DATE RECEIVED BY LOCAL REGISTRAR **OCT 19 1949**

REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**

25. FUNERAL DIRECTOR **Welsh Funeral Home**

ADDRESS **2004 Aliceanna**

VS 150

34659

479

REGISTRAR WRITES PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G78998

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G78998

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Matilda Stahl

2. DATE OF DEATH: Oct 16 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3514 E Lombard

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3514 E Lombard 26-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | married | June 4 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Prell

14. MOTHER'S MAIDEN NAME: Don't know

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mrs Edward Boyce 504 S East Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) Pul Edema — 1 da
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 — 49 *to* Oct 16 — 49 *that I last saw the deceased alive on* Oct 15 — 49 *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: E Boyce M. D.

23B. ADDRESS: 600 N Dallas St

23C. DATE SIGNED: 10-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct 20th

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem

24D. LOCATION (City, town or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Ulrich Funeral Home 2005 Orleans

VS 150

131a

MEHRTENS ✓

G78999

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

181

G78999

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John Mehrtens

2. DATE OF DEATH: Oct 14 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3319 Monument
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3319 Monument — 26 10

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept 8 1880
9. AGE (In years last birthday): 69
If under 1 year: Months, Days
If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10B. KIND OF BUSINESS OR INDUSTRY: The Hub
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Christian Mehrtens
14. MOTHER'S MAIDEN NAME: Bertha Eyglen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Adelaide Mehrtens — ADDRESS: 3319 Monument

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of bladder. — (INTERVAL BETWEEN ONSET AND DEATH) 10 Mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Fibroid stenosis — 18 Years

19A. DATE OF OPERATION: Jan. 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of bladder
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 26, 1949, *to* Oct. 14, 1949, *that I last saw the deceased alive on* Oct. 13, 1949, *and that death occurred at* 11:20 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm J Schmidt, M. D.
23B. ADDRESS: 701 N. Kenwood ave.
23C. DATE SIGNED: 10/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 18 '49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Countersigned Williamsport, Md
25. FUNERAL DIRECTOR: Ulman Funeral Home — ADDRESS: 2008 Aliceanna

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52C

G75000

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G75000

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) SAMUEL By HOFFMAN

2. DATE OF DEATH 10/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3633 Dolfield Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cashier | Restaurant | BALTIMORE | US |

13. FATHER'S NAME Isaac HERTZ Hoffman

14. MOTHER'S MAIDEN NAME Anna Belle —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Della Hoffman ADDRESS 3705 Fulton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fatal Coronary Thrombosis
DUE TO
ANTECEDENT CAUSES
(B) Arteriosclerosis (MI)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. DIABETES MELLITUS

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-15- 1949 *to* 10-16 1949, *that I last saw the deceased alive on* 10-16- 1949, *and that death occurred at* 8:50 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mal Miller, M. D. | Sinai Hospital | 10/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-18-49 | Bnai Israel | Balto; Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | Jack Levin, Inc. | 2100-02 Eutaw Place |

VS 150

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61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G75001 BALTIMORE CITY HEALTH DEPARTMENT G75001

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) WASILI SUBACH

2. DATE OF DEATH Oct. 14. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 144 N. Linwood ave

c. Length of stay in Baltimore 30 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 144 N. Linwood ave 6-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1895 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Maker
10B. KIND OF BUSINESS OR INDUSTRY Mt Clare Shops
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Sam Subach
14. MOTHER'S MAIDEN NAME anna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO 705-03-6150
17. INFORMANT Rose Subach ADDRESS 144 N. Linwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | 7 weeks |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Coronary Occlusion | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-23, 19 49 to 10/14, 19 49 *that I last saw the deceased alive on* 10/8, 19 49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Sol Smith M. D.
23B. ADDRESS 1223 E. Oak Ave
23C. DATE SIGNED 10/15/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 18-1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Balto. City.

DATE RECEIVED BY LOCAL REGISTRAR OCT 17 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. S. Fialkowski 2007 Eastern Ave

VS 150 30Y 47 94a

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 3 3 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREDRICK H. LOY

2. DATE OF DEATH: Oct. 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Franklin Sq. Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): accident room FRANKLIN SQUARE Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6020 CECIL AVE.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept 17-1878
9. AGE (In years last birthday): 71 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trucker or Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fowden County, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard
14. MOTHER'S MAIDEN NAME: Lydia Best

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral accident due

DUE TO

(B) arteriosclerosis & cardio

DUE TO

(C) vascular accident

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION: none
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): none

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? none

22. *I hereby certify that I attended the deceased from* 10 a.m. Oct 15, 1949, *to* 1 p.m. Oct. 16, 1949, *that I last saw the deceased alive on* Oct. 16, 1949, *and that death occurred at* 1.25 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward Burger M. D.
23B. ADDRESS: Franklin Sq. Hosp.
23C. DATE SIGNED: Oct. 16/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 10-19-49
24C. NAME OF CEMETERY OR CREMATORY: Methodist-Taylorstown
24D. LOCATION (City, town, or county) (State): loudon Co., Va.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M R Eichorn Son Frederick Md
ADDRESS:

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G75003 775 ✓ 171 G75003

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Ella Smith

2. DATE OF DEATH: 10-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 507 ROBERT STREET

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widow | Cyrus 2, 1874 | 75? | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Brown
14. MOTHER'S MAIDEN NAME: Ann or Anna Bliza (D)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Carcinoma with ~~metastasis to chest~~ of cervix with extension into body of uterus. | |
| DUE TO | ~~Wall~~ | |
| (B) | ~~Metastasis to lungs~~ | |
| DUE TO | | |
| (C) | (over) | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-21, 1944, *to* 10-14, 1949, *that I last saw the deceased alive on* 10-14, 1949, *and that death occurred at* 1:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. L. Cozzens M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED: 10-14-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1651 Pennsylvania Ave

VS 150

48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be completed. If unknown, state so. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G73004 BALTIMORE CITY HEALTH DEPARTMENT G73004

# CERTIFICATE OF DEATH

Registered No. E 9760

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John G Haynes N-862-4
2. DATE OF DEATH: 10/15/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — So. Balto. Hosp.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
c. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 646 Patapsco Ave 2-5-04
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W.
8. DATE OF BIRTH: 1-14-1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Arundel Corp.
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Marshall Haynes
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Family — ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) .32 Gun Shot Wound Cheek with — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) Hemothorax Massive Depression

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 646 Patapsco Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 15, 1949 1:25 P m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Self Inflicted Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy ☒, Inspection or Inquiry ☒ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☒, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 10/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-11-49
24C. NAME OF CEMETERY OR CREMATORY: Glen Haven
24D. LOCATION (City, town, or county) (State): Glen Burnie
DATE RECEIVED BY LOCAL REGISTRAR: 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James L. McCauley — ADDRESS: 1305 Light St.

VS 151 602 VS 164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G7-90-5736 G75005

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 007

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Joyce

2. DATE OF DEATH: 10-14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 116 S. Culver St. 20 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | July 7- 1883 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Joyce
14. MOTHER'S MAIDEN NAME: Winfield Kelly
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records: ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Tuberculosis | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20- , 1948, *to* 10-14 , 1949 *that I last saw the deceased alive on* 10-14 1949, *and that death occurred at* 10.15A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Lozen M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 10/18/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: 10/17/1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James L. McCarthy
ADDRESS: 130 E. Fort Ave.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item on this certificate should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Important: correct age is especially important.

13B

G7.006 ✓ G7.006

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Etta Johnson

2. DATE OF DEATH 10/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 532 Pontiac Avenue 24-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | March 26, 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Overstreet

14. MOTHER'S MAIDEN NAME Martha A. Trent

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Family - Same. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE-ARTERIOSCLEROTIC HEART DISEASE

DUE TO

ANTECEDENT CAUSES

— DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. CEREBRAL ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 5 49, 19__, *to* 10/13/49, 19__, *that I last saw the deceased alive on* 10/13/49, 19__, *and that death occurred at* 1:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Samuel P. Scalia M. D.

23B. ADDRESS 1213 Light Street (30)

23C. DATE SIGNED 10/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) B

24B. DATE 10-17-49

24C. NAME OF CEMETERY OR CREMATORY Gr. Haven

24D. LOCATION (City, town, or county) (State) Glen Burnie

DATE RECEIVED BY LOCAL REGISTRAR OCT 17 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR James L. McGarvey ADDRESS 130 E. Fort Ave. 93D

VS 150

94a G70007

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 94a G70007

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Robinson
2. DATE OF DEATH: OCT 13 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-02
D. STREET ADDRESS (If rural, give location) 1307 E. Madison St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Negro | Sep. | Jan. 30-1906 | 43 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | Baltimore | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wesley Gilman | Julia ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Coronary Occlusion
DUE TO
(C) Arteriosclerosis of Coronary Arteries

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (Give address or location) |
|---|---|---|
| | | CERTIFICATION APPROVED BY B.S. Fisher for: John R. Davis, M.D. CHIEF OR ASST. MEDICAL EXAMINER |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 10 19 , *to* 10-13 , 1949, *that I last saw the deceased alive on* 19 , *and that death occurred at* 220 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Lukens M.D. | | 10-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 17-49 | Mt. Calvary Cem. | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams M.D. | Chas. O. Wilson | 1044 Broadway |

VS 150

To be Approved by Med. Examiner 94a ap

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G79008

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79008

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Joseph O'Neill

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: 5 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
24 S. Fremont Road
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 24 S. Fremont Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 2/22/1899 | 50 | 7 | 24 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Police Officer
10B. KIND OF BUSINESS OR INDUSTRY: Balto. City Police Dept.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William O'Neill
14. MOTHER'S MAIDEN NAME: Catherine French
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Helena O'Neill
ADDRESS: 24 S Fremont Road, Balto

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, Spontaneous — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive Cardio-Vascular —

DUE TO

(C) Disease —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl Kaye M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 18 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/19/49
24C. NAME OF CEMETERY OR CREMATORY: St. Marys Cem.
24D. LOCATION (City, town, or county) (State): Glenester, Md.
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Easton Sons Catonsville Md.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished accurately and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G70009

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G70009

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): CATHERINE E. COUGHLIN

2. DATE OF DEATH: 10/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2901 Belmont Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2901 Belmont Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | - | Ireland | |

13. FATHER'S NAME: (Dr) John McNulty

14. MOTHER'S MAIDEN NAME: (Dr) Catherine McNulty

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | DD |
|---|---|---|---|
| | --- | Miss Mary Coughlin | 2901 Belmont Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO

(B) Arteriosclerotic Cardio-Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 4, 1940, to Oct. 14, 1949, *that I last saw the deceased alive on* Oct. 14, 1949, *and that death occurred at* 1:45A., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel B. Wolfe M. D. | 133 E. North Ave | 10-15-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/17/49 | Cathedral | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Hemmington Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

ES-1324 [illegible]79010

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 1 G79010 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Jackson

2. DATE OF DEATH: 10-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1024 MOUNT STREET / 6 0 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widowed | Aug. 31, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | N.C. | |

13. FATHER'S NAME: William Burton

14. MOTHER'S MAIDEN NAME: Janie ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: RECORDS* BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | (INTERVAL BETWEEN ONSET AND DEATH) |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Vascular Accident. | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertension. | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Cholecystitis. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-13-49 | Chronic cholecystitis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-7 *, 19*49*, to* 10-15 *, 19*49*, that I last saw the deceased alive on* 10-15 *, 19*49*, and that death occurred at* 3:25 m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Rogers M.D. | 4940 EASTERN AVENUE | 10-17-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 10/19/49 | Roxboro N.C. | Clay Co Chapel |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR (ADDRESS) |
|---|---|---|
| OCT 17 1949 | [illegible] | Metropolitan Funeral Home Inc. 427 N. Wolfe St. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

127a

G73011 G73011

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 44

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Simpson

2. DATE OF DEATH: Oct 15.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 562 W. University Parkway

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore City — B. COUNTY: Md.
C. CITY OR TOWN: Baltimore Md. (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 562 W. University Parkway 13 2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | Widow | Sept 16.1858 | 91 | 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | retired | Balto. Md. | U.S. |

13. FATHER'S NAME: Peter Quinn

14. MOTHER'S MAIDEN NAME: Annie Jamison

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Harold Rickards | 562 W. University Park |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular-renal disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Oct 15, 1949 *that I last saw the deceased alive on* Oct 14, 1949 *and that death occurred at* 9 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm N. McFaul M.D. | 1800 N. Charles St | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Oct.18.1949 | Greenmount Cemetery | North & Greenmount Aves |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | JOHN O. MITCHELL & SONS | 1800 Eutaw Place |

Vs 150

John O. Mitchell Sons.

13/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Physicians: please write the cause of death clearly and legibly. Important: correct age is especially important.

G79012

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79012 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Bauernschmidt — 2. DATE OF DEATH Oct. 15-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hosp

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-03
D. STREET ADDRESS (If rural, give location) 5011 Arabia Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 25-1878 | 70 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Am. H. Whiting Co.
10B. KIND OF BUSINESS OR INDUSTRY Marine Hdwe
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John Bauernschmidt
14. MOTHER'S MAIDEN NAME Elizabeth Marr
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Jennie Bauernschmidt ADDRESS 5011 Arabia

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
I (A) Arteriosclerotic Cardio-Vascular disease
(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Emil T. Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED 16 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/17/49
24C. NAME OF CEMETERY OR CREMATORY Parkwood
24D. LOCATION (City, town, or county) (State) Balto Md
DATE RECEIVED BY LOCAL REGISTRAR OCT 17 1949
REGISTRAR SIGNATURE
25. FUNERAL DIRECTOR Conrad J. Luck ADDRESS 5305 Harford Rd

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Enoch Jasper Haga

2. DATE OF DEATH: October 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: 7 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baldwin. (Rural)
D. STREET ADDRESS (If rural, give location): Carroll Manor Road

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: October 2, 1876
9. AGE (In years last birthday): 73 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Henry Haga.
14. MOTHER'S MAIDEN NAME: Betty Rheimer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: George Haga, ADDRESS: Sparks Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 18 days |
| DUE TO (B) | Arteriosclerosis | 10 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Paralysis Agitans | 10 years. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October 10, 1949, to October 17, 1949, that I last saw the deceased alive on Oct. 17, 1949, and that death occurred at 2:45 A m., from the causes and on the date stated above.

23A. SIGNATURE: Merrill F. Tuttle M. D.
23B. ADDRESS: Union Mem. Hosp.
23C. DATE SIGNED: 10-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 20, 1949
24C. NAME OF CEMETERY OR CREMATORY: Grace
24D. LOCATION (City, town, or county) (State): Chestnut Ridge Balto Co

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Sanders M. Brooks, ADDRESS: Sparks, Md

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Harvey C. Morrison

2. DATE OF DEATH 10/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2049 Druid Park Drive
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2049 Druid Park Drive 1 3 - 0 8

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | July 13, 1874 | 75 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Yardmaster (retired) | Railroad | Baltimore, Md. | |

13. FATHER'S NAME
- Morrison

14. MOTHER'S MAIDEN NAME
Louisa Fowble

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | | Mrs. Clifford W. Church - 716 Northern Pkwy. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| John R Ward M.D. | | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/19/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 17

Registered No.

1. NAME OF DECEASED (Type or Print): MRS Charlotte MacCarthy

2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
C. Length of stay in Baltimore: 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severna PARK
D. STREET ADDRESS (If rural, give location): —

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: JAN. 6, 1870
9. AGE (In years last birthday): 79 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Theodore Harrison
14. MOTHER'S MAIDEN NAME: MARIA COX
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Howard MacCarthy - 100 W. University Pkwy. ADDRESS

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Rt. Breast — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO with metastasis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Esophageal diverticulum — 2 years

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/17, 1949, *to* Oct 17, 1949 *that I last saw the deceased alive on* Oct. 17, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lee M. Howard M.D.
23B. ADDRESS: Church Home and Hosp.
23C. DATE SIGNED: 10/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/19/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNOR & SONS
ADDRESS: Balto., Md.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79016

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79016

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL FELTMAN N-864 4

2. DATE OF DEATH: October 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1509 W. Fayette Street 19-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Mar. 25, 1897 | 52 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Albany, N.Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gabriel Feltman
14. MOTHER'S MAIDEN NAME: Rose Schiffman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): World No 2
16. SOCIAL SECURITY NO:
17. INFORMANT: David Silberg, Albany, N.Y.
ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Exsanguination
DUE TO Multiple gunshot wounds of abdomen and extremities
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found in front of 1522 W. Fayette Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 17, 1949 4:15 A.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Per: RS Fisher EARL L. ROYER, M.D. M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR
23C. DATE SIGNED: 10-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 10/17/49
24C. NAME OF CEMETERY OR CREMATORY: Beth Emeth
24D. LOCATION (City, town, or county) (State): Albany, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Hunter Williams M.D.
25. FUNERAL DIRECTOR: William Cook, Inc., 1217 St. Paul St.
ADDRESS:

VS 151

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered; if unknown, state so. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-2168

1. NAME OF DECEASED (Type or Print): Baby Boy Stapf

2. DATE OF DEATH: October 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. 11 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 173 Baltimore Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Child | 10-5-49 | | | 11 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Douglas Stapf

14. MOTHER'S MAIDEN NAME: Shirley Hauck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Malrotation of the intestines with volvulus of midgut

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-6-49 - 10-16-49 | As above - | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-6, 1949 *to* 10-16, 1949 *that I last saw the deceased alive on* 10-16, 1949, *and that death occurred at* 10 44 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W. Haney M. D. | JOHNS HOPKINS HOSPITAL | 10-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | OCT 17 1949 | HOLY REDEEMER | 4430 BELAIR RD MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 17 1949 | Huntington Williams M.D. | Duffel Bro 800 E Lombard St. |

VS 150

122 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79018 x ✓ 4.3 G79018

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Eleanor Pond Watson 5-16-574

2. DATE OF DEATH: OCT 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: A. A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgewater
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | White | married | 3-13-1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Saleslady | | Md. | |

13. FATHER'S NAME: Joseph A. Lee
14. MOTHER'S MAIDEN NAME: Minnie Chaney

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary edema | 1 day |
| DUE TO (B) | Anemia and hemorrhage in lungs. | 1 wk |
| DUE TO (C) | Acute leukemia. | 3 wks |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Syphilis, late treated

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-6- 1949 *to* 10-17- 1949, *that I last saw the deceased alive on* 10-17- 1949 *and that death occurred at* 2.40 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Evan Calkins M.D. | JOHNS HOPKINS HOSPITAL | 10/17 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 19/49 | Dumbarton Memorial Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 17 1949 | Huntington Williams, M.D. | R. L. Riggin's Sons Baltimore Md |

VS 150

309

PLEASE WRITE PLAINLY. WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. Be sure correct age is especially important.

FS. 13G79019

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79019 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Estelle Clark

2. DATE OF DEATH: 10- 16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 44 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 138 W. Hamburg ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | 7- 31-1890 | 59 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Washington D.C. | |

13. FATHER'S NAME: Richard Blair

14. MOTHER'S MAIDEN NAME: Sarah Williams

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Records Balto. City Hospitals 4940 E ste Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Heart Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized Arteriosclerosis | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Diabetes Mellitus | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* B- 30- , 19 49 , *to* 10- 16- , 19 49 *that I last saw the deceased alive on* 10- 16- 19 49 *and that death occurred at* 4. 00 m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Rogers M. D. | B.C.H. 4940 Eastern Ave. | 10- 17- 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 20, 49 | Payne Mem | Washington, D.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 17 1949 | Huntington Williams M.D. | Charles R. Law. 802 Madison Ave. 61 |

VS 15 6-48

PLEASE WRITE PLAINLY. Use ink. Only [illegible] correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79020 G79020

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

81 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Susan E. Swadner

2. DATE OF DEATH: Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen. Hosp.
c. Length of stay in Baltimore: 20 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 1276 Riverside Ave. 24-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed. | Feb. 28-1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Libertytown Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George Null
14. MOTHER'S MAIDEN NAME: Louise Swadner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ella Todd ADDRESS: 1276 Riverside Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) C A of Bladder | |
| | DUE TO (B) Metastases | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* Oct 15, 1949, *and that death occurred at* 11:49 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John A. Sarno M. D.
23B. ADDRESS: 40 Eastmine Ave
23C. DATE SIGNED: Oct 16 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-18-1949
24C. NAME OF CEMETERY OR CREMATORY: Fairmount
24D. LOCATION (City, town, or county) (State): Libertytown Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

VS 150

52 B

PLEASE WRITE PLAINLY. USE INK. DO NOT ABBREVIATE. Give full name of deceased. Fill in all items. Be sure to give correct age. Cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G79021

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Avis E. Registered No. G79021

1. NAME OF DECEASED (Type or Print) Avis Hopper (AVIS E. HOPPER) 2. DATE OF DEATH Oct. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hosp. to L

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp. to L

c. Length of stay in Baltimore Lifetime Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md. 27-10
D. STREET ADDRESS (If rural, give location) 517 Beaumont ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Dec. 7, 1892. | 56 | 10 | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Albert Parr | Sarah Gough (GOUGH) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Daughter | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct. 15, 1949 | Cholelithiasis | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 15, 1949 *to* Oct. 17, 1949, *that I last saw the deceased alive on* Oct. 17, 1949 *and that death occurred at* 8:55 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mary E. Matthews M.D. | Mercy Hosp. to L | Oct. 17, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/19/49 | Morrland Park | Parkville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | H. Cook Inc. | 1217 St. Paul St. |

VS 150

126

PLEASE WRITE PLAINLY. Please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

AB-132523
G79022

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79022

BIRTH NO. 49-22833

1. NAME OF DECEASED (Type or Print): Baby Girl Buzzerd

2. DATE OF DEATH: 10-12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgemere
D. STREET ADDRESS (If rural, give location): Rose Bank Road- Box 331 zone 22

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | Oct. 11-1949 | 1day | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Maryland | |

13. FATHER'S NAME: George Wm. Buzzerd

14. MOTHER'S MAIDEN NAME: Betty Sanders

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity
DUE TO Fetal Atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-11- , 1949, *to* 10-12- , 1949, *that I last saw the deceased alive on* 10-12- 1949, *and that death occurred at* 9.40A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. S. Ozer M. D. | Baltimore City Hospitals | 10-14-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 10-15-49 | B.C.H. Crematory | 4940 Eastern Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | |

PLEASE WRITE PLAINLY. DO NOT USE ABBREVIATIONS. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

159

G79023 ✓ X G79023

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-22194 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Harrison (435193)

2. DATE OF DEATH: October 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore -Catonsville
D. STREET ADDRESS (If rural, give location): 407 Winters Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | October 10, 1949 | | | 1 / 44 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wilbur Harrison
14. MOTHER'S MAIDEN NAME: Margaret Mc Cain
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 N. Broadway

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B) Immaturum Birth.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 10, 1949 *to* October 10, 1949, *that I last saw the deceased alive on* October 10, 1949 *and that death occurred at* 6:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: M Anderson M. D.
23B. ADDRESS: 601 N. Broadway
23C. DATE SIGNED: 10-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Destroyed by Hospital
24D. LOCATION (City, town or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

PLEASE WRITE PLAINLY with pen and ink. Be sure that the cause of death is stated correctly and that the age is entered. Physicians: please write the causes of death clearly and legibly. Your correct age is especially important.

A 73362 Hospital case ✓ 360.5 G79024

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 1949-22509

1. NAME OF DECEASED (Type or Print): Baby boy Pearson 322501

2. DATE OF DEATH: OCT 9 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days: 6 days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 YOUNG Court. X ✓-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | | 10-2-49 | | | 6? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Thomas Pearson

14. MOTHER'S MAIDEN NAME: Rose ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial hemorrhage
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-2- , 1949 *to* 10-9- , 1949 *that I last saw the deceased alive on* 10-9- , 1949, *and that death occurred at* 1255 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lloyd Blackman M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Baltimore City Hospitals | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 10 1949 | Huntington Williams, M.D. | | |

VS 150

159

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

G79025

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 19 2 G79025 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lonnie Ray

2. DATE OF DEATH: 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

C. Length of stay in Baltimore: 27 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1811 Etting St. 14.03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M/E | COLORED | MARRIED | 1-24-1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LABORER | COPPER WORKS | FEDERAL N. C. | U. S. A. |

13. FATHER'S NAME: RAY

14. MOTHER'S MAIDEN NAME: UNKNOWN

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | LONNIE RAY | 1811 ETTING ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) miliary tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-15-, 1949 to 10-15, 1949 *that I last saw the deceased alive on* 10-15-1949, *and that death occurred at* 1.05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph C. Leman M. D. | 23B. ADDRESS: U. H. | 23C. DATE SIGNED: 10-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: 10-20-49 | 24C. NAME OF CEMETERY OR CREMATORY: MT. CALVARY Hebrew | 24D. LOCATION (City, town, or county) (State): A. A. Co. MARYLAND

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949 | REGISTRAR'S SIGNATURE: Instructor for Williams, M.D. | 25. FUNERAL DIRECTOR: A. HALSTEAD | ADDRESS: ~~918 DRUID HILL AVE.~~

VS 150

Charles H. Wiegand
1200 McCulloh St 3B

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Be correct age is especially important.

G79026

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

33 V

G79026

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): STANLEY SMITH

2. DATE OF DEATH: 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. [illegible]
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto Hosp
c. Length of stay in Baltimore: Yrs. 25 Mos. 4 Days 0

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 702 W Lombard St

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Aug 2 1884 | 65 6 2 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Saloon Keeper
11. BIRTHPLACE (State or foreign country): Balt.
12. CITIZEN OF WHAT COUNTRY? Yes
13. FATHER'S NAME: ? Smith
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Julia Smith ADDRESS: 702 W Lombard

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Cerebral arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-5-1949 *to* 10-15-1949 *that I last saw the deceased alive on* 10-15-1949 *and that death occurred at* 2:45 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Stanley Gryzan M. D. | So. Balto. Gen. Hosp. | 10-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 18-49 | London Park | Frederick Rd Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | [illegible] Williams, M.D. | Joseph Kasmakas Jr. | 602 Wash |

VS 150

10671 YAZOJIAN 83B Bur.

PLEASE WRITE CLEARLY AND LEGIBLY. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 12-29-49

G7.3027

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

G7.3027

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) ISADORE LOSIN

2. DATE OF DEATH 10-17-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland SINAI HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL
c. Length of stay in Baltimore 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 3424 Park Heights Ave

5. SEX Male
6 COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec 15, 1894 1895
9 AGE (In years last birthday) 53 54 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus. Manager
10B. KIND OF BUSINESS OR INDUSTRY Parking Lot.
11. BIRTHPLACE (State or foreign country) Russia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel
14 MOTHER'S MAIDEN NAME Sobel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17. INFORMANT Fannie Losin ADDRESS 3424 Park Heights Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA of STOMACH c METASTASIS

DUE TO

(B) PERITONITIS

DUE TO

(C) LEAKAGE FROM ANASTAMOSIS?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION Oct. 5, 1949
19B. MAJOR FINDINGS OF OPERATION CARCINOMA of STOMACH c PERIGASTRIC NODE METASTASIS
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 30 1949 *to* Oct 17 1949, *that I last saw the deceased alive on* Oct 17 1949 *and that death occurred at* 4:35 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE Israel Cramer M. D.
23B ADDRESS Sinai Hospital
23C DATE SIGNED Oct 21 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-18-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 18 1949
REGISTRAR'S SIGNATURE Lauriston Williams, M.D.
25. FUNERAL DIRECTOR Jack Levin Inc ADDRESS 210 Eutaw Pl

VS 150

156 84

46 B

PLEASE WRITE CLEARLY and correct age is especially important. Physician: please write the cause of death clearly and legibly.

679028

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 679028

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Rose Cohen

2. DATE OF DEATH: 10/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto Gen. Hospital
C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-03
D. STREET ADDRESS (If rural, give location): 1725 Ruxton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | ? | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Ruben Blander 1725 Ruxton |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Hypertension Arteriosclerotic CVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21G. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-10, 1949, *to* 10-17, 1949 *that I last saw the deceased alive on* 10-17, 1949, *and that death occurred at* 10:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathaniel V. Kemp M. D. | West Baltimore Gen. Hosp. | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-18-49 | Hebrew Mt Carmel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams M.D. | Jack Levine Inc | 2100 Eutaw Pl |

VS 150

937

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

G79029

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

49 Registered No. G79029

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arthur B. Davis

2. DATE OF DEATH: 10/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp

c. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 700 Madison Avenue - 1 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | April 11, 1899 | 50 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Plumbing Contractor | -Rock Hill, S.C. | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Arthur Davis | Annie Lang |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| No | 218-05-1415 | Hannah Davis | 700 Madison Ave - 1 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene of lung — INTERVAL BETWEEN ONSET AND DEATH: Undet

DUE TO

ANTECEDENT CAUSES

(B) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Undet

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/14 1949, *to* 10/15, 1949 *that I last saw the deceased alive on* 10/15, 1949, *and that death occurred at* 1:00 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lewis W. Logan M.D. | Provident Hosp. | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/20/49 | Mount Auburn Cemetery | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Charles R. Law | 802 Madison Ave- 1 |

VS 150 9-47 V9

108

PLEASE WRITE PLAINLY. Physician: please write the cause of death clearly and legibly. Be sure correct age is especially important.

G79030

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79030

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie C. Crum

2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clifton Nursing Home 3302 Clifton Ave.,

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1607 St. Stephen St., 15 06

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 30, 1873
9. AGE (In years last birthday): 76
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Crum
14. MOTHER'S MAIDEN NAME: Ellen Dayhoff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs. Jessie G. Eldridge ADDRESS: 1607 St. Steph

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 hours
DUE TO
(B) Generalized Arteriosclerosis — Palsy left leg and arm — 6 yrs
DUE TO
(C) Cerebral Hemorrhage

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive Cardiovascular Disease — Unknown

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (In or Baltimore City, Md., give street location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

CERTIFICATION APPROVED BY: Earl Koons M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

22. *I hereby certify that I attended the deceased from* 16 October 19 49 *to* 17 October 19 49, *that I last saw the deceased alive on* 16 Oct. 19 49, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: O Bradley Daugherty M. D.
23B. ADDRESS: 3033 W. North ave
23C. DATE SIGNED: 10-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-19-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150

937

I certify that the above is a correct copy of the certificate of death now in the custody of the Registrar of Vital Statistics of Baltimore City. Physicians: please write the cause of death correct age is especially important.

G79031

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79031

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE EDWARD CARROLL MARRIOTT

2. DATE OF DEATH: 10/16/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN. HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 114 Allendale St.

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 1, 1893
9. AGE (In years last birthday): 56 yrs. If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - Fire Dept.
10B. KIND OF BUSINESS OR INDUSTRY: Balto. City
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Marriott
14. MOTHER'S MAIDEN NAME: Emma Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs. Marcella M. Marriott
ADDRESS: 114 Allendale St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) LEFT ILIAC ARTERY EMBOLUS — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) MYOCARDIAL INFARCTION OLD NEW — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/14/49 *to* 10/16 19 49 *that I last saw the deceased alive on* 10/15 19 49 *and that death occurred at* 2:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: WBGH
23C. DATE SIGNED: 10/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/19/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

6 5 9 pm

94a

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G790332

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 60 Registered No. G790332

1. NAME OF DECEASED (Type or Print): AMY AGNES BIRNIE

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3426 Piedmont Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home, 3520 N. Hilton St.

c. Length of stay in Baltimore: 20 yrs. (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | July 29, 1883 | 66 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | England | |

13. FATHER'S NAME: John T. Birnie

14. MOTHER'S MAIDEN NAME: Jane Humphrey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Mrs. Anna L. Cockey | 3426 Piedmont Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | months |
| DUE TO (B) | Chronic Diabetes | years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 7, 1949, *to* Oct. 16, 1949 *that I last saw the deceased alive on* Oct. 16, 1949, *and that death occurred at* 12:10 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank H. Ogden, M. D. | 2201 N. Calvert St. | Oct. 17, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/19/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Wm. J. TICKNER & SONS | Balto., Md. |

VS 150

61

Physicians: please write the causes of death clearly and legibly. Information required is especially important. Be sure that correct age is given.

G7990.33 ✓ 331 G7990.33

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Beatrice Dunderdale Dobbin
2. DATE OF DEATH: Oct 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 212 Stoney Run Lane
Stoney Run Nursing Home
C. Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12 c.
D. STREET ADDRESS (If rural, give location): 102 Tuscany Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | N. | Widow | Oct 22 1875 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Perth Amboy N.J. | U.S.A. |

13. FATHER'S NAME: Cleveland Forbes Dunderdale
14. MOTHER'S MAIDEN NAME: Anna Forbes Parker

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Charles Carroll Jr. | Ellicott City Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | ACUTE PYELITIS + SEPSIS | 1 yr |
| DUE TO | URINARY INCONTINENCE | 1 yr |
| DUE TO | & CEREBRAL HEMORRHAGE | 1 yr |
| (B) | ARTERIOSCLEROSIS | 15 years |
| DUE TO | MYOCARDIAL INSUFF | 1 yr |
| (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph S. Hills M.D. | 1 E Eager St Balto 2 Md | Oct 17 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 18/49 | Grace Church | Elkridge Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Henry W. Jenkins | Lorado 4925 Yorkwood Rd |

VS 150

83a

Please write in ink. Physicians: please write the causes of death clearly and correct age is especially important.

G790:34

AB-101211

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

41 6

G790:34

Registered No.

1. NAME OF DECEASED (Type or Print): Anthony Demuro

2. DATE OF DEATH: 10-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 36yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26 12
D. STREET ADDRESS (If rural, give location): No Home-Baltimor City Hosp-Infirmary

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Aug. 15- 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Anthony Demuro

14. MOTHER'S MAIDEN NAME: Maria Frese ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Record: ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Insufficiency

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Heart Disease

DUE TO

(C) Arteriosclerosis generalized

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-11- , 1946 *to* 10-3- , 1949, *that I last saw the deceased alive on* 10-3- , 19 49 *and that death occurred at* 9.22A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED: 10-14-1949

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, Town, or county) (State):

UNIVERSITY MEDICAL SCHOOL OCT 14 1949

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949

REGISTRAR'S SIGNATURE: [signature] Huntington Williams, Md

25. FUNERAL DIRECTOR:

ADDRESS:

VS 150

958

Please write the causes of death clearly and legibly. Physicians: Correct age is especially important.

G7:0:35

JL - 125616

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

91

G7:0:35

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Peter Oloncewicz

2. DATE OF DEATH: Sept. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals, 4940 Eastern Ave.
C. Length of stay in Baltimore: 46 Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 105 S. Spring St. 3 C 1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Sep. | ? ? ? 1371 | 78 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Poland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Oloncewicz | Annie Postella |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | B. C. H. Records, 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchopneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Malnutrition | |
| DUE TO | | |
| (C) | Carcinoma of Neck | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Aug. 13, 1949 | Prefrontal Lobotomy | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-27-48, 19__, *to* Sept. 29, 1949 *that I last saw the deceased alive on* Sept. 29 1949, *and that death occurred at* 8.16 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Ave. | 10-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | [redacted] MEDICAL SCHOOL | OCT 14 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | [signature] Huntington Williams Jr. | | |

VS 150

5 5 E

A CAUSE OF DEATH must be entered in each of lines (A), (B), (C) and I. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

67:0:36

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50

67:0:36

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) James H Reed

2. DATE OF DEATH Oct 16, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 904 E Monument St
C. Length of stay in Baltimore Yrs. 50 yrs Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-07
D. STREET ADDRESS (If rural, give location) 904 E Monument St

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH Jan 12, 1884
9. AGE (In years last birthday) 65 If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman Cook on Old Bay Line
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Lena Wilkins ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Esophagus — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. —

INTERVAL BETWEEN ONSET AND DEATH: unknown

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-7-, 1949, *to* 10-16-, 1949, *that I last saw the deceased alive on* 10-14-, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm H. Corgill M. D.
23B. ADDRESS 611 N. Caroline St.
23C. DATE SIGNED 10-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 19/49
24C. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery
24D. LOCATION (City, town, or county) (State) Westport Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mr Robert A. Elliott Dft ADDRESS

VS 150

720 51

46a 1129 N. Carlton.

G790537 CERTIFICATE CORRECTED 10-20-49 ✓ 4 20 1 G790537

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Frank J. GRZECHOWIAK (Grezechowiak)

2. DATE OF DEATH: Oct. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION ("If not in hospital or institution, give street address or location"): Baltimore City Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 826 1828 E. Pratt St. Now S. Luzerne Av

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | Nov. 16 1899 | 49 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Labor | | Baltimore Md. | U.S.A. |

13. FATHER'S NAME: Joseph Grzechowiak

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-01-3980

17. INFORMANT: Julia Grzechowiak ADDRESS 826 S. Luzerne

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary thrombosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Oct. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | October 19 1949 | Holy Rosary Cem. | Balto. County |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Hunter for Williams, M.D. | John M. Weber | 401 S. Chester St. |

VS 151

94a

PLEASE WRITE PLAINLY, in ink, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G790:58

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 Registered No. G790:58

BIRTH NO

1. NAME OF DECEASED (Type or Print) Antonina Tylus

2. DATE OF DEATH Oct 15 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4 Culver Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 35 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimare
D. STREET ADDRESS (If rural, give location) 4 Culver Street 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year: Months / Days. If under 24 hours: Hours / Min.) |
|---|---|---|---|---|
| F | W | Widow | Nov 15 1898 | 50 51 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Andrzej Kupera

14. MOTHER'S MAIDEN NAME Anastasia Kusa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Frank Tylus ADDRESS 6428 Donnel St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(B) Hypertensive Vascular Disease — Years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 16, 1949 *to* Oct 15, 1949, *that I last saw the deceased alive on* Not seen, 19___ *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Abram Goldman M.D. | 206 S. Gilmor St. | Oct 17, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 19 1949 | Holy Rosary Cem. | Baltimare Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10 19 49 | Huntington Williams, M.D. | John M. Weber | 401 S. Chester Street |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

CERTIFICATE CORRECTED 10-21-49

G790:39 G790:39

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah A. Quarengesser.

2. DATE OF DEATH: Oct 17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1639 Clifview.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1639 Clifview Ave

c. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1639 Clifview Ave 8-05-

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug 15th 1866 | 83 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | — | Balto Md | USA |

13. FATHER'S NAME: Jerome Quarengesser

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Jerome Quarengesser ADDRESS: 1639 Clifview

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH): 1 hour

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease 3 years — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Auricular fibrillation — 3 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 1947 *to* Oct. 17, 1949 *that I last saw the deceased alive on* Oct. 14, 1949, *and that death occurred at* 8 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Greene | 1402 E. Lanvale St | 10.17.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 20/49 | Moreland Mem | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Ulman Funeral Home | 2008 Orleans |

VS 150

93D

Physicians: please write the causes of death clearly and legibly. Be as correct age is especially important.

G79040

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

583

G79040

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Carnatt Jackson

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 259 N. Exeter St.

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH:
9. AGE (In years last birthday): 35 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: David Hall
14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Floyd Jackson ADDRESS: Alexander, Va.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatitis-subacute-toxic-agent unidentified
~~acute~~ Nephrosis-Toxic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Unknown
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Unknown
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Unknown m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] Unknown
21F. HOW DID INJURY OCCUR? Undetermined

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ]*

23A. SIGNATURE: Edward Voigt M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 10-18-49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Greenspring, Virginia.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Francis A. Hensley ADDRESS: 518 W. Biddle St

VS 151

125B

Please write clearly and legibly. Physicians: please write the causes of death clearly and correct age is especially important.

G79041

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17° Registered No. G79041

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CAROLINE M. SCHAFER
2. DATE OF DEATH: 10-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1513 E Fort AVE
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1513 E. FORT AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 8-9-1890 | 59 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waterville Tipper | | Washington D.C. | U.S.A. |

13. FATHER'S NAME: Edward J. Schafer
14. MOTHER'S MAIDEN NAME: Mary CAA

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | — | 212-09-8361 | Mary | Schafer |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Terminal Bronchopneumonia | 15-24 hr. |
| DUE TO (B) | Carcinoma of Breast. | 1-2 yr. |
| DUE TO (C) | Metastatic Carcinoma of Cervical Spine & Brain | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Feb 1948, 19__, *to* Feb 16 d, 1949, *that I last saw the deceased alive on* 10-16-49 19__, *and that death occurred at* 7:30 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. B. Clough M.D. M.D. | 692 Nash Blvd | 10-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-19-49 | Holy Cross | B.A. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Charles F. Dill | 1501 E. Fort Ave |

VS 150
R.V. RANGLE

50

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79062

BALTIMORE CITY HEALTH DEPARTMENT 165

# CERTIFICATE OF DEATH

G79062

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Oscar Asendorf

2. DATE OF DEATH: 10 · 15 · 49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: 18 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 803 Walnut Ave. Balto Md - 29
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21 · 04
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | Feb. 15, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CLERK | Revere Brass + Copper | Balto. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John H. Asendorf | Katherine Lerch |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 212-01-2957 | Robert L. Asendorf | 4401 Pokeby Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pulmonary embolus — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) Possible pneumonia c pleurisy

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Possible pulmonary infarct.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 10, 1949 *to* Oct. 15, 1949 *that I last saw the deceased alive on* Oct. 14, 1949, *and that death occurred at* 5:15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul O. Manning M. D. | Bon Secours Hosp. | 10/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 19/49 | Loudon Pk. | 3801 Frederick Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Harry N. Nitzke | 401 Edmondson Ave |

VS 150

266 31

110 B

Physician: please write the causes of death clearly and legibly. The correct age is especially important.

679043

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 679043

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHANNA HUBERT

2. DATE OF DEATH: 10/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 4020 Woodridge Rd # 29

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W | 8. DATE OF BIRTH: 2/28/77 | 9. AGE (In years last birthday): 72 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Walters
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. ADDRESS: 4020 Woodridge R.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis
DUE TO
(B) Coronary sclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Arterial occlusion, left leg.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/27/49 *to* 10/17/49, *that I last saw the deceased alive on* 10/17/49, *and that death occurred at* 10 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Block M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 10/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 20/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Eastern Ave. Essex, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry A. Mutzfeld ADDRESS: 4101 Edmondson Ave.

VS 150

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67904

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

Registered No. 67904

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lena white

2. DATE OF DEATH: 10-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.

C. Length of stay in Baltimore: 15yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): City. 15-01
D. STREET ADDRESS (If rural, give location): 1328 N. Fremont ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C. | M. | 3/26/1908 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Domestic | Warrenton, N.C. | U.S.A. |

13. FATHER'S NAME: Julius Brandt

14. MOTHER'S MAIDEN NAME: Hargie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | Elijah White | 1328 N.Fremont Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Nephritis | |
| DUE TO | uremia | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 3 OCT, 1949, *to* 14 OCT, 1949 *that I last saw the deceased alive on* 3 OCT, 1949, *and that death occurred at* 12:12 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph H Kinnaman M. D. | University Hospital | 14 OCT 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/49 | Mt. Auburn Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Funeral Director for Williams, M.D. | Chas. H. Harper | 512 Cancelled Ave |

VS 150

132

Physicians: please write the causes of death clearly and correct age is especially important.

G790-45 GK 132016 ✓ E824.0 G790-45

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Mason — N-820.0

2. DATE OF DEATH: 10- 15- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: 14-03
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore ~~Crownsville State Hospital~~ rural
D. STREET ADDRESS (If rural, give location): 2215 Druid Hill Ave ~~Crownsville State Hospital~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Widowed | ? ? ? | 75 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | ? | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? | ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Records Balto. City Hospital | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pneumonia | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Fracture of Neck of right Femur | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerotic Cardiovascular Disease | |

CERTIFICATION APPROVED BY
B B Baker
CHIEF OR ASST. MEDICAL EXAMINER. M. D.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9- 20- 49 | McMurray Osteotomy | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Hospital Grounds | Crownsville State Hospital |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 9-20-49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fell from truck (In motion) |

22. *I hereby certify that I attended the deceased from* 9- 20- , 1949, *to* 10- 15- , 1949, *that I last saw the deceased alive on* 10- 15- 1949, *and that death occurred at* 1.-5 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. L. Rogers M. D. | B.C.H. 4940 Eastern Ave. | 10- 18- 49 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/18/49 | St. Peters | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Chas Harper 5½ Cancelled | |

VS 150 -- To Be Approved by the Chief Medical Examiner.

170a

Physicians: please write the cause of death clearly and legibly. Be sure age is especially important.

G7906 BS-132614

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G7906

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Cirero Wilson

2. DATE OF DEATH: 10-16-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 9 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto
D STREET ADDRESS (If rural, give location): 669 W. Fairmount Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | April 30, 1912 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | BETH. STEEL | N.C. | |

13. FATHER'S NAME: James

14. MOTHER'S MAIDEN NAME: Tiny Glasky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17 INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningitis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Miliary Tuberculosis — DUE TO

(C) — DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-14 1949 *to* 10-16 1949, *that I last saw the deceased alive on* 10-16 1949, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B ADDRESS: 4940 EASTERN AVENUE

23C DATE SIGNED: 10- 17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped

24B. DATE: 10/19/49

24C. NAME OF CEMETERY OR CREMATORY: Salisbury N.C.

24D. LOCATION (City, town, or county) (State): Salisbury N.C.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949

REGISTRAR'S SIGNATURE: [signature] Registrar for Baltimore, Md.

25. FUNERAL DIRECTOR: Mrs Katie R. W Elliott

ADDRESS: 322

VS 150

13B

Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G7.50:7 — 131809

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

446 — G7.50:7

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Bertha Nelson

2. DATE OF DEATH: 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 26 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 306 N. Calhoun St. 19-01

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 21, 1913
9. AGE (In years last birthday): 36 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Hunter
14. MOTHER'S MAIDEN NAME: Ora Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Hypertensive renal disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12- , 19 49 , *to* 10-15- , 19 49 *that I last saw the deceased alive on* 10-15- 1949 , *and that death occurred at* 8:30 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Rosen M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 10-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/19/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: OCT 19 1949
25. FUNERAL DIRECTOR: Miss Katie R. Williams
ADDRESS: 3 22 Schroeder

VS 150

1230

Please write clearly and legibly. Physicians: please write the causes of death as correctly as is especially important.

G79048 G79048

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Vol. Registered No.

1. NAME OF DECEASED (Type or Print): ALVERTA MIDDLETON

2. DATE OF DEATH: OCT. 16 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3429 ROLAND AVE
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 13-06
D. STREET ADDRESS (If rural, give location): 3429 ROLAND AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | JUNE 10 1870 | 79 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): KENT CO. MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: JOHN A ROLLISON
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr W² MIDDLETON ADDRESS: 3429 ROLAND AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs.
DUE TO
(B) Coronary Artery Disease
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 15, 1949 *to* Oct 16, 1949 *that I last saw the deceased alive on* Oct 15, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward Levin Kessman M. D. | 4017 Falls Rd. | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | OCT. 19 '49 | MEADOWRIDGE | DORSY, MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Contagion Hill Clinic, M.D. | Harry A Wyche | 410 Edmondson Ave |

VS 150

94a

correct age is especially important. Physician: please write the cause of death plainly.

G7:0:9 G7:0:9

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 4700

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM B. RODENHI, Sr.

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2913 W. Lanvale St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2913 W. Lanvale St. 16-06

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 21, 1865
9. AGE (In years last birthday): 84 yrs. (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cutter (retired)
10B. KIND OF BUSINESS OR INDUSTRY: Box Mfgrs.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas Rodenhi
14. MOTHER'S MAIDEN NAME: Louise Keifel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Grace W. Rodenhi - 2913 W. Lanvale St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis | 20 minutes |
| DUE TO (B) | Arterio sclerotic type heart disease with cardiac hypertrophy & chronic myocarditis & generalized arterio sclerosis | Several years |
| DUE TO (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cellulitis of right leg below knee — 4 weeks.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: 0
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 13, 194 *to* Oct 16, 1949 *that I last saw the deceased alive on* Oct 16, 1949 *and that death occurred at* 330 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm Michel, M. D.
23B. ADDRESS: 1015 Poplar Grove St.
23C. DATE SIGNED: Oct. 17 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10.19.49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Deputy for Wilhelmina, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150 496 IV 93D

G79050 G79050

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WARREN S. LLOYD

2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 23rd & St. Paul Sts.

C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2117 N. Charles St. 12 06

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Divorced | Sept. 28, 1893 | 56 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Gas Machinery | Baltimore, Md. | |

13. FATHER'S NAME: Joseph S. Lloyd

14. MOTHER'S MAIDEN NAME: Mary E. Wenzel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes — World War #1 | 214-14-5943 | Mr. Charles R. Lloyd | 5005 Embla Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis | Immediate |
| DUE TO | | |
| (B) | Myocarditis + Coronary Thrombosis Insufficiency | Indefinite |
| DUE TO | | |
| (C) | Chr. Glomerular nephritis & Uraemia | Indefinite |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct, 1936 *to* Oct 17, 1949 *that I last saw the deceased alive on* Oct 16, 1949, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathaniel M Beck M. D. | 100 E. 23rd St Baltimore | Oct 17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10.19.49 | Mt. Olivet Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 155

Correct age is especially important. Physician: please write the causes of death only as directed by this registry.

131 B

G79051

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79051

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Briscoe

2. DATE OF DEATH: Oct. 17 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL (If not in hospital or institution, give street address or location)

B. FULL NAME OF HOSPITAL OR INSTITUTION

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16 03

D. STREET ADDRESS (If rural, give location): 1016 N. Gilma St

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years; last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | | 9-26-76 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| R.R. Laborer | | Md | |

13. FATHER'S NAME: Lewis Briscoe

14. MOTHER'S MAIDEN NAME: Harriet Marshall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of stomach | 12 mos. |
| | DUE TO (B) | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/28, 19 49, *to* 10/17, 19 49, *that I last saw the deceased alive on* 10/17, 19 49, *and that death occurred at* 8 45 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip D. Hagen M. D. | JOHNS HOPKINS HOSPITAL | Oct. 17, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21 1949 | St. Joseph | Charles Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

46B

Physician: please write the cause of death clearly. Accuracy and correct age is especially important.

G7903?2

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

49° Registered No. 2

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH BLACK GRAHAM

2. DATE OF DEATH: Oct. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 206 Aisquith Street
c. Length of stay in Baltimore: 18 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 206 Aisquith Street

5. SEX: Famale
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 17, 1931
9. AGE (In years last birthday): 18 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James L. Black
14. MOTHER'S MAIDEN NAME: Gladys Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Gladys Graham
ADDRESS: 206 Aisquith St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
(B) Lobar Pneumonia — 4 Days.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10.11, 1949 *to* 10.14, 1949 *that I last saw the deceased alive on* 10.14, 1949, *and that death occurred at* 9:30 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. DeLoy Dewey, M. D.
23B. ADDRESS: 1420 E. Chase
23C. DATE SIGNED: 10.17.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 18 1949
24C. NAME OF CEMETERY OR CREMATORY: Int. Anchora
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

108

Physician: please write the causes of death legibly. Information is especially important. Be correct age is especially important.

ES-190499 G73056

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

16 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bernard Smith

2. DATE OF DEATH: 10-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals
C. Length of stay in Baltimore: 35 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1100 CARROLLTON AVENUE 16-01

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 26, 1886?
9. AGE (In years last birthday): 63?
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Smith
14. MOTHER'S MAIDEN NAME: Cecelia Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Broncnogenic Carcinoma. | |
| | DUE TO (B) | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cystitis. | |

19A. DATE OF OPERATION: 9-13-49
19B. MAJOR FINDINGS OF OPERATION: Bronchoscopy Amputation 4th Right finger
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1949, *to* 10-17, 1949, *that I last saw the deceased alive on* 10-17 1949, *and that death occurred at* 4:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: P. L. Rogers M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED: 10-17- 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct.
24C. NAME OF CEMETERY OR CREMATORY: St. Peters
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS 1691 Druid Hill Ave 47

VS 150

Please write plainly. Physician: please write the cause of death clearly. Correct age is especially important.

G7.0:54 ✓ G7.0:54

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 17

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles S. Lillard

2. DATE OF DEATH: Oct. 16 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3712 Arcadia Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3712 Arcadia Ave 7-18

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 8/96 | 53 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trouble Shooter
10B. KIND OF BUSINESS OR INDUSTRY: Gas Electric Co
11. BIRTHPLACE (State or foreign country): Luray Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 212-05-5891
17. INFORMANT: Mrs Sallie Armstrong Lillard 3712 Arcadia Ave

## MEDICAL CERTIFICATION

Physicians: please write the causes of death clearly and correct age is especially important.

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Oct. 18 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 19/49
24C. NAME OF CEMETERY OR CREMATORY: Balto National
24D. LOCATION (City, town, or county) (State): Baltimore Md
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949
REGISTRAR'S SIGNATURE: Thurston Williams M.D.
25. FUNERAL DIRECTOR: Loring Byers 5005 Pk Hgts Ave.

94a

VS 151 49653

G790.5 ✓ G790.5

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY S. BLADES

2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1121 N. Longwood St.

c. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1121 N. Longwood St. 16-C 7

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hrs. / Min. |
|---|---|---|---|---|---|---|
| Female | White | Divorced | Nov. 20, 1887 | 61 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Frederick Co., Md. | |

13. FATHER'S NAME: Joseph H. Groff

14. MOTHER'S MAIDEN NAME: Mary E. Gideon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mr. Allen Groff | Route #1, Frederick, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Hypertension Cardio Vascular Disease

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 19 46 *to* Oct. 17 19 49, *that I last saw the deceased alive on* Oct 17 19 49, *and that death occurred at* A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| N. E. Needle M. D. | 914 W. North Ave | 10/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/20/49 | Mt. Carmel Cem. | Frederick Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

N. E. NEEDLE

93D

Correct age is especially important. Physician: please write the cause of death plainly.

7790:56

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

760.0

7790:56

BIRTH NO. 49-21387 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Smith

2. DATE OF DEATH: 10/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2304 ELLINGS 1403

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIV. Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days: 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | N | Single | 10-1-49 | | — / 3 | — / — |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dependent

10B. KIND OF BUSINESS OR INDUSTRY: INFANT

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Rogers Smith

14. MOTHER'S MAIDEN NAME: Lillie Belle Singleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO: none

17. INFORMANT: Same ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hematoma — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) precipitous delivery — DUE TO

(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct. 1, 1949, *to* Oct. 4, 1949, *that I last saw the deceased alive on* Oct. 4, 1949, *and that death occurred at* 3:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS:

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL OCT 14 1949

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 18 1949

REGISTRAR'S SIGNATURE: [signature]

25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS:

VS 150

correct age is especially important. Physicians: please write the

160a

7790:47

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4500 Registered No. 7790:47

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN H. HUFF

2. DATE OF DEATH September 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION ("If not in hospital or institution, give street address or location")
681 W. Fayette Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 681 W. Fayette Street 4-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | U | U | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| K | K | K | |

13. FATHER'S NAME — O

14. MOTHER'S MAIDEN NAME — O

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Carl H. Meyer M.D. | | Sept. 27, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | OCT 14 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 18 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

97

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G7905 8

G7905 8
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 900 o Registered No.

1. NAME OF DECEASED (Type or Print): SKAPIK John N-804

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland SINAI HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 912 N. Bradford 7-03

c. Length of stay in Baltimore: 45 Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 24 1893
9. AGE (In years last birthday): 56 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bohemia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Adam Skapik
14. MOTHER'S MAIDEN NAME: Anna Soukover
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Marie Skapik ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage + Pulmonary Edema.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral contusion, fracture of skull + bone, dislocated cervical vertebrae
DUE TO

(C) Fractures of both radii
Diabetes Mellitus

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

CERTIFICATION APPROVED BY
P. H. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 912 N. Bradford St. Balto Md
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 10/5/49 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ft. fall down flight of stairs

22. I hereby certify that I attended the deceased from _____, 19 49 to 10/16, 19 49, that I last saw the deceased alive on 10/15, 1949, and that death occurred at 1:35 p. m., from the causes and on the date stated above.

23A. SIGNATURE: Harold Benoit, M. D. M. D.
23B. ADDRESS: Sinai Hosp Baltimore
23C. DATE SIGNED: 10/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-19-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE, M.D.

25 FUNERAL DIRECTOR: George Enoch ADDRESS: 900 N. Chester

VS 150

186a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G790:59 ✓ Vol. 1 G790:59

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Margaret Henning

2. DATE OF DEATH: Oct. 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 200 Harmison Street

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20 03
D. STREET ADDRESS (If rural, give location): 200 Harmison Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Jan. 29 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Seamstress | Clothing | Maryland | U.S.A. |

13. FATHER'S NAME: Charles F. Henning

14. MOTHER'S MAIDEN NAME: Louise Dorsch

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 212-10-4905 | Louise C. Henning | 200 Harmison St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C) Coronary Insufficiency

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/12/, 1949, *to* 10/18/, 1949, *that I last saw the deceased alive on* 10/18/, 1949, *and that death occurred at* 5:15 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. Martin Jr. M.D. | 1933 W. Baltimore Street | 10/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21, 1949 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | George L. Schwab | 2101 Frederick Ave. |

VS 150

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G730c0

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G730c0

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Coulbourne

2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sulé
D. STREET ADDRESS (If rural, give location): 2828 Brookman St

c. Length of stay in Baltimore: Yrs. 16 Mos. Days 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Single | About 1872 | About 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Treasurer
10B. KIND OF BUSINESS OR INDUSTRY: Culvert Hat Co
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alfred Coulbourne
14. MOTHER'S MAIDEN NAME: Margaret S Lyons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Drummond ADDRESS: 2828 Brookman St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial decompensation
DUE TO
(B) Myocardial infarction; coronary
DUE TO
(C) atherosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pulmonary infarction

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 17, 1949 *to* Oct. 18, 1949 *that I last saw the deceased alive on* Oct. 18, 1949 *and that death occurred at* 11:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Fred R. McClumpha, M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 10/18

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 10/20/49
24C. NAME OF CEMETERY OR CREMATORY: Dulle Haven
24D. LOCATION (City, town, or county) (State): Accomac Co. Va.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible] 217 N. Paul St.

VS 150

Fred R. McClumpha, Jr. 93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G790x2 G790x2

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 no. 1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Henry Onion
2. DATE OF DEATH: Oct 18th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1001 St. Paul st.
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1434 Homestead st. 9-05

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 24th 1893
9. AGE (In years last birthday): 56 — If under 1 year: Months / Days; If under 24 hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manufacturer
10B. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (State or foreign country): Dixie, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: John W. Onion
14. MOTHER'S MAIDEN NAME: Ella L. Shuss
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W.W. #1
16. SOCIAL SECURITY NO.
17. INFORMANT: Ella G. Onion — ADDRESS: 1434 Homestead st

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Inspection

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William B. Kelbach M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 10-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/21/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Deputy for Matthews, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc — ADDRESS: 1217 St. Paul St

VS 151

94a

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G790:52

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G790:52

Registered No. 44

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theresa Silvski (Klimczak)

2. DATE OF DEATH: 10 / 17 / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2513 Durham St # 31

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 10-15-1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

13. FATHER'S NAME: Joseph Plum

14. MOTHER'S MAIDEN NAME: Julia Kapitan

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Subarachnoid Hemorrhage | 3 hrs |
| DUE TO (B) | Hypertensive Cardiovascular Renal disease | several years |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Pulmonary edema Contusion of Parietal left side | appx 3 hrs prior to death |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | home | as above |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10-17-49 6 p.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Patient became dizzy + fell left side of forehead |

22. *I hereby certify that I attended the deceased from* 10-17, 1949 *to* 10-17, 1949 *that I last saw the deceased alive on* 10-17, 1949 *and that death occurred at* 6.50 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Cadle | Md. Gen'l Hosp | 10-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 21/49 | Holy Cross | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | Fred W. Ozarowski | 735 Eastern Ave |

VS 150

Medical Examiner approved release of body under above diagnosis M. L. Cadle M.D. 10/21/49

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G790n3 ✓ G790n3

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN WESLEY STEFFE

2. DATE OF DEATH: October 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2729 Cylburn Avenue 27-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec-28-1882 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10B. KIND OF BUSINESS OR INDUSTRY: Iron & Steel

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George T. Steffe

14. MOTHER'S MAIDEN NAME: Annie Kirkman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) None (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 718-12-0768

17. INFORMANT: Mary W. Steffe (wife) ADDRESS: 2729 Cylburn Ave.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Generalized arteriosclerosis

DUE TO

(C) Fractured hip, right

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

E 840 X 1

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 1. Street 2. Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1. Hamburg & Howard Streets 2. South Baltimore General Hospital

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 1. 9-21-49 12:05 p.m. 2. 9-23-49 ? m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? 1. Pedestrian struck by streetcar 2. Fell from hospital bed

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil H Beyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 10-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct-19-1949

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Stewart & Mowen Company, 108 W. North Ave.

VS 151 N-820 0

171a City #1. ✓

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

AB-132687

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 175

Registered No. G7904

Birth No. 7904

1. NAME OF DECEASED (Type or Print): Mae Buellis

2. DATE OF DEATH: 10-17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1133 Sargent St. zone 23

21-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Married | May 29- 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: George Page

14. MOTHER'S MAIDEN NAME: Laura Welch

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT: Records: ADDRESS: Baltimore City Hospitals 4940 Eastern Ave. |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma (from ovary) djm

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-17- , 1949, *to* 10-17- , 19 49 *that I last saw the deceased alive on* 10-17- , 19 49, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Cozen M. D. | Baltimore City Hospitals | 10-17-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/21/49 | Mt. Christ | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | [illegible] | 217 St. Paul St. |

VS 150

TO BE APPROVED BY MEDICAL EXAMINER

OVER

49a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67305 ✓ 67305

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 67305

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEON GOULD

2. DATE OF DEATH: September 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 29 W. Preston Street 11-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 14, 1893 | 56 | 5 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Recfton New Zeleland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Veterans Adm. ADDRESS

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. V. Sukowski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 9-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Oct. 13/49
24C. NAME OF CEMETERY OR CREMATORY: Balto Nat
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: E. Furnace cost 5118 Eyre Oak ADDRESS

VS 151

94a ✓ cvc

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G790n6 G790n6

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 796

BIRTH NO. 49-32986

1. NAME OF DECEASED (Type or Print) KENNETH JOSEPH PIOTROWSKI

2. DATE OF DEATH 10/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.

c. Length of stay in Baltimore: Yrs. — Mos. — Days 1 Day

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore-2815 E. Chase St
D. STREET ADDRESS (If rural, give location) Franklin Square Hosp. E.03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Boy | White | Single | 10/8/49 | | | | 16 | 20 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant. | — | Maryland | Maryland. |

13. FATHER'S NAME Melvin K. Piotrowski

14. MOTHER'S MAIDEN NAME Mary Pistorio

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | — | Mother | 2815 E. Chase St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity - B.W. 12lb 3/4 oz.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. I hereby certify that I attended the deceased from 10/8 1949, to 10/8, 1949 that I last saw the deceased alive on 10/8, 1949, and that death occurred at 5:25 P.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Counter M. D. | Franklin Square Hosp. | 10/13/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL OCT 14 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

159

correct age is especially important. Physicians: please write the cause of death plainly.

6790:47 6790:47

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 60

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN SANDLER

2. DATE OF DEATH: 10-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: Length of time before admission)
A. STATE: Md
B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levendale

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 40 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): Levendale 27-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Shoe maker | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Meyer | Sarah |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Anna Rosensweig | 3309 Garrison |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Coronary sclerosis — years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Diabetes mellitus — years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Tumor right eye ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-7 19 49 *to* 10-18 19 49, *that I last saw the deceased alive on* 10-18 19 49 *and that death occurred at* 1045 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry Nagel, M.D. | Levendale Home | 10-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-19-49 | Hebrew Herzog Cem | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

61

Correct age is especially important. Physicians: please write the

Correct age is especially important. Physicians: please write the

67908 ✓ No. 1 67908

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Hale

2. DATE OF DEATH: 10/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1128 W. Hamburg St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-04
D. STREET ADDRESS (If rural, give location): 1128 W. Hamburg St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | Widowed | 1/12/1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Meat Packer | Cork Hill Co | Baltimore Md. | U S A |

13. FATHER'S NAME: Andrew Hale

14. MOTHER'S MAIDEN NAME: Wiliamenia Lang

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓ (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs William Hale ADDRESS: 1128 W Hamburg St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary thrombosis | immediate |
| DUE TO | | |
| (B) | Hypertensive cardio vascular disease | ? |
| DUE TO | | |
| (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — — — | — — — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — — | — — — | — — — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/16/ , 1949 *to* 10/17/ , 1949, *that I last saw the deceased alive on* 9/16/ , 1949 *and that death occurred at* 10.45 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Deiel M. D. | 1226 Hanover Street, | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/20/49 | New Cathedral | 4300 Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | John J. Cowan & Son | 939 Wolfe St. |

VS 150

G790t9 43 G790t9

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Rosa Wilhelmina Schneider

2. DATE OF DEATH: Oct 17 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1604 Cliftview Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 64 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1604 Cliftview Ave 8-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Nov 2 1884 | 64 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Housewife | Baltimore Md | |

13. FATHER'S NAME: Jacob Schneider

14. MOTHER'S MAIDEN NAME: Mary Eisner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 215-09-2379 | Michael Schneider | 1604 Cliftview Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C. V. D

DUE TO

(B) Arteri-Sclerosis

DUE TO

(C) Ureteral Obstruction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 14, 1949 *to* Oct 17, 1949 *that I last saw the deceased alive on* 10/17, 1949 *and that death occurred at* 4 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hamilton Hankins M. D. | 5331 Eastern Ave | 10/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 21 1949 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | Harry G. Simmons | 4204 Ridgewood Ave |

VS 150

Correct age is especially important where person is under one year or one day

93

G790.70

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163 Registered No. G790.70

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stanton H. Slusky

2. DATE OF DEATH: October 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 15 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2234 Linden Ave. 13-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 12-19-33 | 15 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry D. Slusky
14. MOTHER'S MAIDEN NAME: Rea Bernstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Metastatic lung sarcoma | 4 mos. |
| | DUE TO | |
| ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-30, 1949 *to* 10-18, 1949 *that I last saw the deceased alive on* 10-18, 1949, *and that death occurred at* 8 25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph D. B. King
23B. JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 20, 1949
24C. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
24D. LOCATION (City, town, or county) (State): Rogers AVe Balto, Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bro
ADDRESS: 1126 N

VS 150

47D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

79071 X 79071

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 9 2 0 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MIKE STEFAN

2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE -22 Dundalk
D. STREET ADDRESS (If rural, give location): Box 2830 NORTH POINT RD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M | 1918 | 31 | - | - | - | - |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ELECTRICIAN | SELF | PA. | U. S. A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN

16. SOCIAL SECURITY NO.: 172-18-6157

17. INFORMANT: ESTELLE STEFAN ADDRESS: SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | RESPIRATORY (MEDULLARY) FAILURE | |
| DUE TO | CEREBRAL ANOXIA | |
| | PROTEUS SEPTICEMIA | |
| (B) | LATERAL SINUS THROMBOSIS (RIGHT) | |
| DUE TO | NECK ABSCESSES (right + left) | |
| (C) | ACUTE MASTOIDITIS + OTITIS MEDIA (RIGHT ACUTE) | |

19A. DATE OF OPERATION: 10/8/49 10/11/49

19B. MAJOR FINDINGS OF OPERATION: I&D abscess right neck, mastoidectomy, lat. sinus right thrombectomy

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 9/29/, 1949, to 10/18/, 1949 that I last saw the deceased alive on 10/18/, 1949, and that death occurred at 5:22 P. m., from the causes and on the date stated above.

23A. SIGNATURE: J. F. Rosenhead Jr. M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 10/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/21/49

24C. NAME OF CEMETERY OR CREMATORY: Glen Haven

24D. LOCATION (City, town, or county) (State): Richmond Hwy

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Langahm Funeral Home ADDRESS: 2401 Belair

VS 150

89a

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

7.10.72 — 31 — 67.10.72

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CLARENCE OTTEY

2. DATE OF DEATH: Oct. 16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5007 E Oliver St
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26
D. STREET ADDRESS (If rural, give location): 5007 E. Oliver St. 44

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: July 2 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Textile inspector
10B. KIND OF BUSINESS OR INDUSTRY: J. J. Hanson
11. BIRTHPLACE (State or Foreign Country): Phila. Pa Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry J. Ottey
14. MOTHER'S MAIDEN NAME: Gertrude Frost

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 216 07 5338
17. INFORMANT: Harry Ottey ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | about ½ hr. |
| DUE TO (B) | Arteriosclerosis | unknown |
| DUE TO (C) | Hypertension, essential. | unknown |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 Oct, 1949, *to* 16 Oct, 1949, *that I last saw the deceased alive on* 16 Oct, 1949, *and that death occurred at* 12:10 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Huntington Williams M. D.
23B. ADDRESS: 1516 N. Milton Ave
23C. DATE SIGNED: 16 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 20-1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Jos. J. Stern + Son 83a 3001 Kentucky Ave.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

790 73

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 6790 73

1. NAME OF DECEASED (Type or Print): Elizabeth C. Rebbel

2. DATE OF DEATH: Oct. 17-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1700 Rutland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: M D.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-8
D. STREET ADDRESS (If rural, give location): 1700 Rutland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | June 24 1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ~~August C. Rebbel~~ Charles Peters
14. MOTHER'S MAIDEN NAME: Barbara Unterwagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (ADDRESS): Augusta C. Rebbel

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive & Arteriosclerotic Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO
(B) Chronic nephritis — 5 yrs.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia — 1 weeks.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1942 *to* Oct. 17, 1949, *that I last saw the deceased alive on* Oct. 16 1949, *and that death occurred at* 2:00 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Brengel M. D. | 1402 E. Fairmount St | 10-18-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21-1949 | Holy Redeemer | Baltimore |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Penitentiary Baltimore, Md.
25. FUNERAL DIRECTOR (ADDRESS): Jos. J. Stein & Son 3001 Kentucky Ave

131B

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

79074 — 67507.4

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Henry Lee
2. DATE OF DEATH: 10-18-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Provident Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp. & Free Disp.
C. Length of stay in Baltimore: Life. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 1808 N. Broadst. Balto. Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1514 Division st. Balto., Md.
D. STREET ADDRESS (If rural, give location): 14-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male. | Negro. | married. | 8/31/880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Superintendent. | Insurance | Balto., Md. | U.S.A. |

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Nancy ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO:
17. INFORMANT: Consuella Lee — ADDRESS: 808 N. Mount St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypostatic Pneumonia | 14 days |
| DUE TO (B) | Arteriosclerotic H.T. disease | 10 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Benign Prostatic Hypertrophy (Post op) | 45 days |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/3/49 | Benign Prostatic Hypertrophy | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8/24, 19 49 *to* 10/18, 19 49 *that I last saw the deceased alive on* 10/18, 19 49, *and that death occurred at* 5:00 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas C. Walden M.D. | Provident Hospital | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 21-49 | Mt. Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | James A. Hayes | 638 N. Gilmor St. |

VS 150

correct age is especially important. Physicians: please write the cause of death in plain English—avoid abbreviations.

137a

G750'75

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G750'75

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William E. Cole

2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6014 York Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6014 York Rd. 27-12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Nov. 28, 1884 | 64 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Physician | Own Medical practice | Cannonsburg, Pa. | |

13. FATHER'S NAME: Wesley G. Cole

14. MOTHER'S MAIDEN NAME: Catherine Blanch Litle

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Louise S. Cole | 6014 York Rd. |

## MEDICAL CERTIFICATION

CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection Only *thereon and from the evidence obtained by said* (Autopsy, Inspection or Inquiry) *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| Thos R Deaver, M.D. | | 10/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/21/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

83a

correct age is especially important. Physicians: please write the cause of death carefully and legibly.

G790.6

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

G790.6

Registered No.

1. NAME OF DECEASED (Type or Print): REESE THOMAS AKERS

2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital 2724 N. Charles St.

C. Length of stay in Baltimore: all his life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2749 Maryland Avenue 13-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | divorced | Sept. 15, 1900 | 49 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard (Police) | Maryland Dry Dock | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Daniel L. Akers

14. MOTHER'S MAIDEN NAME: Jennie Browney

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 213-12-7931 | Mrs. Emma Wright | 1406 Webster St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-17-, 1949 *to* 10-17-, 1949 *that I last saw the deceased alive on* 10-17, 1949 *and that death occurred at* 2:55 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J Glass M.D. | 2730 N Charles St | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/20/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

83a

correct age is especially important; please write the number

G7.0.7 G7.0.7

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 578 Registered No.

1. NAME OF DECEASED (Type or Print): Charles J. Brooks Sr. | 2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-0x
D. STREET ADDRESS (If rural, give location): 989 Abbott Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 1/19/1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Boiler Room | Virginia | |

13. FATHER'S NAME: Charles Brooks
14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO. |
|---|---|---|
| yes | Spanish American | |

17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Peritonitis
DUE TO Perforation of colon
(B) unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-16-49 | Generalized Peritonitis & marked ileus | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — a. m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 10-16-, 1949 *to* 10-17-, 1949 *that I last saw the deceased alive on* 10-17-, 1949, *and that death occurred at* 2.30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Lawrence Jr. M. D. | JOHNS HOPKINS HOSPITAL | 10-17 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/20/49 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| OCT 19 1949 | Evington Williams M.D. | Pott & B.M. Walter Pratt Sticker Jr. |

VS 150

123

correct age is especially important. Physicians: please write the cause of death very plainly.

G79078

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79078

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Philip J. Smith

2. DATE OF DEATH: Oct. 18-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 927 N. Castle St. 7-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 927 N. Castle St.

C. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Jan. 13-1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Feed Business | | Balto. Md. | |

13. FATHER'S NAME: Smith

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Helen Tyler | 927 N. Castle St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Secondary Mororytic Anemia | 2 mo. |
| DUE TO | | |
| (B) | Probable Carcinoma of Stomach | 1 yr. |
| DUE TO | | |
| (C) | | |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 5 *,* 19 49 *to* Oct. 18 *,* 19 49 *, that I last saw the deceased alive on* Oct. 18 *,* 19 49 *and that death occurred at* 5:10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jos. M. Zimmerman M. D. | 2858 Harford Blvd. | 18 Oct. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21-49 | Baltimore Gen. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | John A. Miller | 2334 Jefferson St. |

VS 150

46B

G79079 ✓ G79079

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4-20

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Anna Menton (MENTON)
2. DATE OF DEATH: 10-17-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1726 Caroswell St. 9-07
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Nov. 16-1873
9. AGE (In years last birthday): 75 76
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: USA.
13. FATHER'S NAME: John Hoyer
14. MOTHER'S MAIDEN NAME: Rose ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Christina Menton — ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bl. Multiple Pulmonary Infarctions
DUE TO Sec Left Femoral Thrombosis
DUE TO Cerebral Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Acute Acute Ant. Myocardial Infarction

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 26 1949, to Oct 17, 1949, that I last saw the deceased alive on 10-11, 1949, and that death occurred at 1:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE: H. H. Smith Jr. M. D.
23B. ADDRESS: Univ. Hosp
23C. DATE SIGNED: 10-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 20-49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore — Md
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: F. P. Wippert & Son — 1300 Eastern Ave. 17

94a

G79080

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

45

Registered No. G79080

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helena Bailey

2. DATE OF DEATH: October 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 2316 Druid Hill Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 44 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | 6-13-05 | 44 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Duvall
14. MOTHER'S MAIDEN NAME: Anna Ennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardiac Tamponade | 5 min |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Dissecting Aneurysm of aorta | 48 hrs |
| DUE TO | | |
| (C) | Hypertension | 2 yrs |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16, 1949, *to* 10-17, 1949, *that I last saw the deceased alive on* 10-17, 1949, *and that death occurred at* 9 30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: David E. Rogers M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/21/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 1412 E Preston St

VS 150

G79081

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79081
Registered No.

BIRTH NO. 49-09420

1. NAME OF DECEASED (Type or Print): DAVID KAPLAN — 2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore, Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2603 Norfolk Ave. 15-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | 5-8-49 | | 5 / 10 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Solomon
14. MOTHER'S MAIDEN NAME: Rose K.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Solomon Kaplan — ADDRESS: 2603 Norfolk

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Anoxia | |
| DUE TO (B) | Congenital Heart Disease | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/15/49, 19__, *to* 10/18/49, 19__, *that I last saw the deceased alive on* 10/18/49, 19__, *and that death occurred at* 7:15P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leo N. Kastan, M. D. — 23B. ADDRESS: 6 Sinai Hosp — 23C. DATE SIGNED: 10/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 10-19-49 — 24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run — 24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR: Jack Lewis Inc — ADDRESS: 2100 Eutaw Pl

VS 150

157E

G79082 ✓ G79082

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 157

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Adelaide Theresa Gagliardi

2. DATE OF DEATH: October 18, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore

c. Length of stay in Baltimore (Yrs. Mos. Days): 61 yr.

D. STREET ADDRESS (If rural, give location): 5002 Gunther St. 26-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F. | W. | Widowed | Feb. 11-1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Italy | |

13. FATHER'S NAME: Dominick

14. MOTHER'S MAIDEN NAME: Theresa

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr John Rossi | 4814 Pleasant View |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Pancreas.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug. 25, 1949 *to* Oct. 18, 1949, *that I last saw the deceased alive on* Oct. 17, 1949, *and that death occurred at* 12:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Waldemar Swinski M. D. | 1400 N. Caroline St. | Oct. 18, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/22/49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5305 Harford Rd. |

469

G790833

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 334

Registered No. G790833

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1709 North Wolfe Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 82yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 N. Wolfe Street E 06 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

**3 (a) FULL NAME** Minnie Gahm

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. **********

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife **********

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 5-20-1867

8. AGE: Years 82 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name George L. Gahm
13. Birthplace Germany

MOTHER 14. Maiden Name Marie ?
15. Birthplace Germany

16 (a) Informant Mrs. Frank C. Schmitt
(b) Address 1709 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-49 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 5118 Gwynn Oak Ave.

19 (a) (Signature of registrar) Walter Williams, Jr.

OCT 19 1949

## MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1949, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1949 to Oct 18 1949, and that I last saw h[illegible] alive on Oct 18 1949.

| Immediate cause of death | Duration |
|---|---|
| Valvular Heart disease | 2 yrs. |
| Due to | |
| Due to Cerebral Arteriosclerosis | 4 yrs. |
| Other Conditions | |

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Fisher M. D.
Address 1823 N. Broadway Date signed 10/19/49

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

925

G79084 G79084

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 59

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY KATHERING KAUFMAN
2. DATE OF DEATH: OCTOBER 18 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: 9 (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 7-01
D. STREET ADDRESS (If rural, give location): 725 N. STREEPER ST.
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: JAN. 9, 1940
9. AGE (In years last birthday): 9 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: VINCENT KAUFMAN
14. MOTHER'S MAIDEN NAME: Lillian Trcka
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Parents, 725 N. Streeper Street ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic glomerular nephritis. DUE TO
INTERVAL BETWEEN ONSET AND DEATH: one month

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 10, 1949, *to* Oct. 18, 1949 *that I last saw the deceased alive on* Oct. 18, 1949, *and that death occurred at* 12:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul O. Mannix M. D.
23B. ADDRESS: Bon Secours Hospital
23C. DATE SIGNED: 10/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 22, 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison Street

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

131 R

G79085 ✓ G79085

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. / 51 Registered No.

1. NAME OF DECEASED (Type or Print): READY BELCHER

2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 101 S. Spring St. 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | col | Married | 10/25/94 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | NC | USA |

13. FATHER'S NAME: Westharper Belcher ?

14. MOTHER'S MAIDEN NAME: Easter ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| Yes — WW I | ? | Records- US Marine Hospital, Balto, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach with generalized metastases (postoperative) — Interval between onset and death: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 4/14/49 | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22 *I hereby certify that I attended the deceased from* Sept. 15, 1949, *to* Oct. 19, 1949 *that I last saw the deceased alive on* Oct. 19 1949 *and that death occurred at* 3:45 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or County) (State) |
|---|---|---|---|
| Burial | Oct. 24-49 | Balto. Mt. Cem. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | Elroy S. Wilson, 1000 Brantley Rd |

VS 150

46B

correct age is especially important. Physicians: please write the causes of death clearly.

G79086 X Trone ✓ G79086

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stanley Trone

2. DATE OF DEATH: 10-19-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): York
D. STREET ADDRESS (If rural, give location): 458 Park Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | w | | Feb. 29, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| copy Reader | York Dispatch | York, Pennsylvania | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John S. Trone | Magdalena Hamme |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Strack & Strine, York, Pennsylvania |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism, [illegible] pneumonia, [illegible]. — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) Pernicious anemia — 1 yr

INTERVAL BETWEEN ONSET AND DEATH: immediate

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-12, 1949 *to* 10-19, 1949, *that I last saw the deceased alive on* 10-19, 1949, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ramsey Nichols M.D. | University Hospital | 10-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| removal | 10/19/49 | Green Mount | York, Pennsylvania |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 19 1949 | Curtis Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

730a

correct age is especially important. Physicians please write the cause of death plainly

G75087 ✓ G75087

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1949

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Louise M. Shea

2. DATE OF DEATH 10/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18
D. STREET ADDRESS (If rural, give location) 2305 Homewood Ave. 9-08

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 15, 1897
9. AGE (In years last birthday) 52 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William E. Wroten
14. MOTHER'S MAIDEN NAME Lusby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/12/49, 19__, *to* 10/17/49, 19__, *that I last saw the deceased alive on* 10/17/49, 19__ *and that death occurred at* 3:22 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Samuel D. Scalia, M. D.
23B. ADDRESS 1213 Light St.
23C. DATE SIGNED 10/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE OCT. 20, 1949
24C. NAME OF CEMETERY OR CREMATORY BALTIMORE CEM.
24D. LOCATION (City, town, or county) (State) BALTIMORE MD.

DATE RECEIVED BY LOCAL REGISTRAR OCT 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS FLYNN & FLEMING, 1426 LIGHT ST.

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79088 BALTIMORE CITY HEALTH DEPARTMENT G79088

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter Redman

2. DATE OF DEATH: Oct 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | S. | Aug. 5, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | ? | ? | |

13. FATHER'S NAME: George Redman

14. MOTHER'S MAIDEN NAME: Rosina Fondelayen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Sister Superior | ADDRESS: 1200 Valley St |
|---|---|---|---|

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Carcinoma of Stomach | 1 yr |
| DUE TO | | |
| (B) | Metastasis in Lungs | 1 month |
| DUE TO | | |
| (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 1 *, 1949, to* Oct 17 *, 1949, that I last saw the deceased alive on* Oct 12 *, 1949, and that death occurred at* 11:20 P. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Gill Hall M. D. | 1631 E. North Ave | Oct 19 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 20, 1949 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Cunningham Williams, M | Wm. Diedrich | 900 E. Biddle St 46 D |

VS 150

Dr. Helfrich G79089
5006 Roland Ave.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79089

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | George Adam Mueller |
| 2. DATE OF DEATH | Oct. 18, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 4404 Old York Road |
| c. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 4404 Old York Road 27-10 |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | July 26, 1862 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min. | 87 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Retired |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Maryland |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Matthew V. Mueller |
| 14. MOTHER'S MAIDEN NAME | Anna Marie Keidel |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT / ADDRESS | Mrs. Mary E. Mueller, 4404 Old York R |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Vascular Disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Oct 18 19 49 *to* Oct 19 49, *that I last saw the deceased alive on* Oct 18 19 49 *and that death occurred at* 6 45 *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | William L. Helfrich M. D. | |
| 23B. ADDRESS | 5006 Roland Ave | |
| 23C. DATE SIGNED | Oct 20 49 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 10-21-49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Holy Redeemer | |
| 24D. LOCATION (City, town, or county) (State) | Baltimore, Maryland | |
| DATE RECEIVED BY LOCAL REGISTRAR | OCT 19 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams M.D. | |
| 25. FUNERAL DIRECTOR / ADDRESS | Leonard J. Ruck, 5305 Harford Road. | |

UCS 150

Correct age is especially important. Physicians: please write the cause of death plainly.

937

G75090

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

120.0 G75090 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs Ida Peetz

2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balt. City Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp

c. Length of stay in Baltimore: 36 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltim~~ Dorsey
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | ~~Sept~~ 1/20/78 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Germany | U.S.A. |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Herman Peetz | Dorsey Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive Arteriosclerotic Heart Disease | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/17 19 49, *to* 10/18 19 49, *that I last saw the deceased alive on* 10/18/49 19 , *and that death occurred at* 9 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Urban H. Woods M. D. | West Balt. General Hosp. | 10/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-22-49 | Zion Cemetery | Dorsey, Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 19 1949 | Huntington Williams, M.D. | George L. Schmuck | 2101 Pradium ave. |

93D

correct age is especially important. Physicians: please write the cause of death plainly.

G79091 ✓ G79091

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John D. Christman

2. DATE OF DEATH: 10/18/49 5:45 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1216 Linden Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 11-04
D. STREET ADDRESS (If rural, give location): 1216 Linden Ave

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Jun 16th 1883 | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor | Social Security Board | Hartford Wis | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Peter Christman | Anna Kane |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W. W. #1 | | Catherine Christman | 1216 Linden Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Oct 16 1949 to Oct 18, 1949, that I last saw the deceased alive on Oct 18 1949 and that death occurred at 5:45 A.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis T. Lewy M. D. | 1844 W. North Ave | Oct 19-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/21/49 | U.S. National | Arlington Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Huntington Williams, MD | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

94a

correct age in especially important cases. Physicians: please write out the name of the cause of death in full.

G79092 G79092

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HERBERT HUBERT M. COLE
2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1911 W. Saratoga St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 1911 W. Saratoga St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Divorced | Nov. 24, 1886 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | Western Maryland Daity | Anne Arundel Co., Md. | |

13. FATHER'S NAME: Joseph W. Cole
14. MOTHER'S MAIDEN NAME: Julia C. Wayson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 215-10-8128 | Clara Cole, 1911 W. Saratoga St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tachycardia, right heart dilatation + pulmonary edema. — INTERVAL BETWEEN ONSET AND DEATH: 12 hours.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio vascular disease
DUE TO coronal insufficiency - coronary thickening, chronic nephritis

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1936 *to* 10/19, 1949, *that I last saw the deceased alive on* 10/18, 1949, *and that death occurred at* 2 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D. McCarty M. D. | 37 W. Preston St. | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/22/49 | Quaker | Galesville, A.A.County, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 20 1949 | Huntington Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

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G79093 ✓ X 0 G79093

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOSIAS A. HANCOCK

2. DATE OF DEATH: October 19th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PINE RIDGE NURSING HOME

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: BALTIMORE Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDLE WYLDE
D. STREET ADDRESS (If rural, give location): 902 OAKHILL ROAD

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov 3rd 1863 | 85 | 11 / 16 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocery Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Lumber & Coal Supply Co.
11. BIRTHPLACE (State or foreign country): La Plata Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas T. Hancock
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Chas. A. Hancock 902 Oakhill Rd Idlewylde

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) ARTERIOSCLEROTIC HEART DISEASE | 5 yrs. |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) GENERAL & CEREBRAL ARTERIOSCLEROSIS | 10 yrs |
| DUE TO | | |
| | (C) SENILITY | 1 yr |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | CEREBRAL HEMORRHAGE | 18 mo |

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION: NONE
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NONE
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 9th 1944 to October 19th 1949 *that I last saw the deceased alive on* October 11th 1949, *and that death occurred at* 4:25 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. S. Chalfant M.D.
23B. ADDRESS: 6210 York Rd
23C. DATE SIGNED: Oct 19th 49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/21/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

937

Correct age is especially important. If unknown, please write approximate age.

G79094 ✓ 43 G79094

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. OCT 20 1949

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles BRUNSMAN

2. DATE OF DEATH 10-18-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

c. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-07
D. STREET ADDRESS (If rural, give location) 2532 Robb St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 2-11-1896 | 53 | 8 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant

10B. KIND OF BUSINESS OR INDUSTRY Am. Oil Co.

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME F. Frederick Brunsman

14. MOTHER'S MAIDEN NAME Maria J. Beckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) uremic poisoning

DUE TO

(B) hypertensive cardio vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17, 1949, *to* 10-18, 1949 *that I last saw the deceased alive on* 10-18, 1949 *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Burton V Lock M.D. M. D.

23B. ADDRESS Mercy Hospital

23C. DATE SIGNED 10-18-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) Burial

24B. DATE 10/21/49

24C. NAME OF CEMETERY ~~or CREMATORY~~ London Park

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St. Paul St.

VS 150

93

Correct age is especially important. Physicians: please write the cause of death plainly.

G79095

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 G79095 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis G. Petry

2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 9-08
D. STREET ADDRESS (If rural, give location): 2328 Garrett Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: Aug 17th 1896
9. AGE (In years last birthday): 53 — If Under 1 Year: Months 2, Days 1 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Upholsterer
10B. KIND OF BUSINESS OR INDUSTRY: International Bedding Co
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Anthony Petry
14. MOTHER'S MAIDEN NAME: Louise Rosemeier

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Nellie G. Petry 2328 Garrett Ave

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C-V disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. A. Tulumpas M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 10/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/22/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949
REGISTRAR'S SIGNATURE: Thurlington for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm Cook Inc. 217 St. Paul St.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G79096 ✓ G79096 3

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 3 3

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith Rommgo (ROMINGO)

2. DATE OF DEATH: 10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. 58 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 609 Cumberland

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | May 19-1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Richard Thomas | Rebecca Loppins |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Albert Romingo | 609 Cumberland St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-17-49 *to* 10-18-49, *that I last saw the deceased alive on* 10-18-1949 *and that death occurred at* 6:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. G. Bradyth M. D. | Provident Hosp | 10-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 22 49 | Mt. Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Cunningham Williams M.D | Wm Crooks | 1763 N. Carey St |

VS 150

83a

correct age is especially important. Physicians: please write the causes of death clearly

G79097

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 1 G-79097

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STEWART H. POWERS

2. DATE OF DEATH October 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01
D. STREET ADDRESS (If rural, give location) 803 Mangold Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Married | Jan. 10, 1900 | 49 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cab Driver | | Richmond, Virginia | |

13. FATHER'S NAME: Robert Powers

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Louise Powers | 803 Mangold Street |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) ...m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Kay M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Oct. 19, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 22-49 | Mount Olivet | Frederick Rd Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | [illegible] M.D. | Joseph Kasnekoo Inc | 692 Washington Blvd |

VS 151

correct age is especially important. Physicians: please write out causes of death clearly and legibly.

G75038

G75038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Thomas J. Rosier

2. DATE OF DEATH 10/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10
D. STREET ADDRESS (If rural, give location) 820 McCabe Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| M | W | Married | May 8, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| R.R. Engineer | Penn. R.R. | Carlton, Md. | U.S. |

13. FATHER'S NAME James A. Rosier

14. MOTHER'S MAIDEN NAME Lydia A. Downs

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(B) Arteriosclerotic Heart Disease — years
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/15, 1949, *to* 10/17, 1949, *that I last saw the deceased alive on* 10/17, 1949, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Alfred Rawlins, Jr. M.D. | Franklin Square Hosp. | 10/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Oct. 20 1949 | Pine Grove Cem. | Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 20 1949 | Evelyn Williams, M.D. | Roland H. Fisher Dundalk, Md. |

VS 150

correct age is especially important. Please write

929

G79039 E97 G79039

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE EMERSON N-1534

2. DATE OF DEATH: October 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 1509 W. Fayette Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Divorced | 1888 | 61 Yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Walter H. Emerson.

14. MOTHER'S MAIDEN NAME: — Steele.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 212-16-2098 | Mildred E. Emerson | 3 W. Eager St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet Wound of Brain — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1509 W. Fayette Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 17, 1949 4:20 A m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an ~~Autopsy~~ Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Emil H. Kruger M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 10-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Lincoln Park

24D. LOCATION (City, town, or county) (State): Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Edw. O. Mitchell

ADDRESS:

VS 151

164c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M M 109915 G79100

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

D Registered No. G79100

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Arthur Henson.

2. DATE OF DEATH 10-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto ( Infirmary
D. STREET ADDRESS (If rural, give location) 103 Caroline St. 6-05

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Jan. 30, 1895
9. AGE (In years last birthday) 54 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Walter (DEC)
14. MOTHER'S MAIDEN NAME Carrie (DEC)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Records B.C.H. ADDRESS 4940 Eastern Ave

## MEDICAL CERTIFICATION

CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive Cardio Vascular Disease
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Late Latent Syphilis

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-16, 1947, *to* 10-15, 1949, *that I last saw the deceased alive on* 10-15, 1949 *and that death occurred at* 7.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE C. S. Grogan M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 10-17-1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried
24B. DATE 10/20/49
24C. NAME OF CEMETERY OR CREMATORY Balto. National
24D. LOCATION (City, Town, or County) (State) Balto. Md.
DATE RECEIVED BY LOCAL REGISTRAR OCT 20 1949
REGISTRAR'S SIGNATURE Irving Williams, M.D.
25. FUNERAL DIRECTOR Robert L. Young
ADDRESS 1532 E. Monument St
209

VS 150

correct age is especially important. Physicians: please write the cause of death clearly

G79:01 ✓ G79:01

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 44 ✓

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Ida Feld

2. DATE OF DEATH: 10-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1701 Ellamont St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fenstatt Home
C. Length of stay in Baltimore: 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2126 No Pulaski St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 78

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sarah Malesow ADDRESS: 2126 No Pulaski

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vas. Renal Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture Right Femur

INTERVAL BETWEEN ONSET AND DEATH
(A) 7
10/0/49

19A. DATE OF OPERATION: 10/9/49
19B. MAJOR FINDINGS OF OPERATION: Fracture Head of Femur Rt.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 2126 N. Pulaski - Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) →
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 10/5/49. (10) P m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Vertigo - loss of balance -

22. I hereby certify that I attended the deceased from 10/25/49, 19__, to 10/20, 1949, that I last saw the deceased alive on 10/20, 1949, and that death occurred at 12:30 A m., from the causes and on the date stated above.

23A. SIGNATURE: Joseph S. Blum M. D.
23B. ADDRESS: 1115 No Calvert
23C. DATE SIGNED: 10/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-20-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949
REGISTRAR'S SIGNATURE: Kunkleman for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eastern Ave

VS 150

131a

correct age is especially important. Physician: Please write the cause of death in plain English.

G79:02 G79:02

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ADOLPH AARON JAFFA — 2. DATE OF DEATH: 10-19-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-18 — D. STREET ADDRESS (If rural, give location): 5009 Denmore Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5009 Denmore Ave

c. Length of stay in Baltimore: 45 Yrs. ~~Mos.~~ ~~Days~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Furniture | Latvia | |

13. FATHER'S NAME: Samuel

14. MOTHER'S MAIDEN NAME: not known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Rose Jaffa | 5009 Denmore Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes

DUE TO

ANTECEDENT CAUSES

(B) Coronary insufficiency — 4 mo

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October 19 1949, *to* October 19, 1949, *that I last saw the deceased alive on* Oct 19, 1949, *and that death occurred at* 8:45 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Randolph K. Shipley M. D. | 5010 Denmore Ave | Oct 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-20-49 | Hebrew Friendship | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Huntington Williams M D | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

correct age is especially important. Physician: PLEASE WRITE the cause of death clearly and legibly.

94a

679:03

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679:03 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Smith

2. DATE OF DEATH: Oct. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Dales 2

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 1530 W. Fairmount Ave

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 10-29-1890
9. AGE (In years last birthday): 58 59
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Smith
14. MOTHER'S MAIDEN NAME: Jane Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-18-, 19 49 *to* 10-18-, 19 49 *that I last saw the deceased alive on* 10-18-, 19 49, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul J. Negley, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: Oct. 18, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipping.
24B. DATE: 10-20-1949
24C. NAME OF CEMETERY OR CREMATORY: Monroe N.C.
24D. LOCATION (City, town, or county) (State): Monroe N.C.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams. ADDRESS: 322 N. Schroeder St.

VS 150

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:04

G79:04

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALFRED JOHNSON

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. 19 Mos. 01 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 508 N. Gilmor St

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 7, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Franklin Co. N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sidney Johnson
14. MOTHER'S MAIDEN NAME: Mary Eden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Allen D. Johnson ADDRESS: 508 N. Gilmor St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Congestive Heart Failure | 2 DAYS |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Carcinoma of Stomach | 3 yrs (?) |

19A. DATE OF OPERATION: 9-22-49; 10-6-49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Stomach Post Op. Eviscerating
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 1949 *to* Oct 16, 1949 *that I last saw the deceased alive on* Oct 16, 1949, *and that death occurred at* 2.25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: David Auld M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 10-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 21, 1949
24C. NAME OF CEMETERY OR CREMATORY: W.M. Zion Cem.
24D. LOCATION (City, town, or county) (State): Landsdowne Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 32nd & Edmondson Ave

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

463

G79:05 G79:05

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 334

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Martha Sawyer

2. DATE OF DEATH Oct. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1825 Madison Ave.
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 14-03
D. STREET ADDRESS (If rural, give location) 1825 Madison Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | Feb. 12, 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin Meads
14. MOTHER'S MAIDEN NAME Elizabeth Tilghman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.
16. SOCIAL SECURITY NO
17. INFORMANT Alice Gross ADDRESS 1826 Madison Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Paget's Disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Advanced Cerebral Arteriosclerosis
DUE TO
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C)

INTERVAL BETWEEN ONSET AND DEATH: 4 years

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* Oct 17, 19 49 *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 8:15 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE Thomas Henry Carter JR M. D.
23B. ADDRESS 1715 Pennsylvania Ave
23C. DATE SIGNED Oct. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-21-1949
24C. NAME OF CEMETERY OR CREMATORY W. Laurel Cem
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 20 1949
REGISTRAR'S SIGNATURE Burlington Williams, M.D.
25. FUNERAL DIRECTOR Mr Kates R. Williams
ADDRESS 322 N Schroeder St

V8 150

155

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G79:06 G79:06

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-14953 Registered No. E9 N-933

1. NAME OF DECEASED (Type or Print): JOHN ROCHE
2. DATE OF DEATH: Oct 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lasair Hosp
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River
D. STREET ADDRESS (If rural, give location): 40 Oak Grove Drive.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | single | 3/19/48 | | 15 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ✓ | ✓ | Md | ✓ |

13. FATHER'S NAME: Robert N. Roche
14. MOTHER'S MAIDEN NAME: E Wellings

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | Robert N. Roche | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
DUE TO
(B) Accidental Aspiration of Food
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
[illegible] M.D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Acc. | Home | 40 Oak Grove Drive Middle River Balto Co |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 2 pm 10/19/49 | WHILE AT WORK ☐ NOT WHILE AT WORK X | aspirated while eating piece of apple while at play-pen. |

22. *I hereby certify that I attended the deceased from* Oct 19, 1949 *to* Oct 19, 1949 *that I last saw the deceased alive on* Oct 19, 1949, *and that death occurred at* 3:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jack Wittler M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 9/21/49 | Sacred Heart of Jesus | Balto County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams M.D. | J. J. Bruzgynski | 1407 Eastern Ave. |

VS 150

1950

correct age is especially important. Physician: please write the cause of death plainly.

To be stamped out by medical examiner - October

G79:07

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79:07

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Fannie LEVIN

2. DATE OF DEATH 10-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1925 St Paul St 1-04

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bookkeeper | Shirt Mfg | Baltimore Md | |

13. FATHER'S NAME Israel

14. MOTHER'S MAIDEN NAME Kay

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Dr Harry Levin | 2234 Crest Road |

MEDICAL CERTIFICATION

18. 343 X

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) Intrinsic disease of Brain stem to be determined Histologically. DUE TO

(B) Subarachnoid hemorrhage of pulmonary veins. DUE TO

(C) Transverse myelitis of undetermined etiology

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

over

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-17-49 | Lobe determined Histologically | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-18 19 49 *to* 10-19 19 49, *that I last saw the deceased alive on* 10-19 19 49 *and that death occurred at* 10 00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Freda Cramer M. D. | Sinai Hospital | 10-19 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-20-49 | Hebrew Friendship | Pikesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Thurlington for Williams, Inc. | Jack Lewis Inc | 2100 Eutaw Pl |

correct age is especially important. Physicians: please write the cause of death very plainly.

82

G79:08

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 1411

BIRTH NO. G79:08

1. NAME OF DECEASED (Type or Print): GEORGE MATTHEW KNAUSS

2. DATE OF DEATH: 10/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GEN. HOSP.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-E
D. STREET ADDRESS (If rural, give location): 6312 Brook avenue

5. SEX: M.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Sept. 1, 1883
9. AGE (In years last birthday): 66 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk —
10B. KIND OF BUSINESS OR INDUSTRY: Wholesale Tobacco

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Knauss
14. MOTHER'S MAIDEN NAME: - Winters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Eva Maria Knauss — ADDRESS: 6312 Brook Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Embolism
DUE TO
(B) duodenal Perforated Ulcer
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 10 days

19A. DATE OF OPERATION: 10/19/49.
19B. MAJOR FINDINGS OF OPERATION: Perforated duodenal ulcer
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/9/49 *to* 10/20/49 *that I last saw the deceased alive on* 10/19/49 *and that death occurred at* 1.35a m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. G. Martin M. D.
23B. ADDRESS: Maryland General Hosp.
23C. DATE SIGNED: 10/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/22/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

VS 150

11765

correct age is especially important. Physicians: please write the cause of death clearly

G79:09

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

57 Registered No.

G79:09

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Johanna Seth

2. DATE OF DEATH 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-07
D STREET ADDRESS (If rural, give location) 165 N Monastery Ave

5. SEX Female
6. COLOR OR RACE White
7 SINGLE, MARRIED WIDOWED DIVORCED (Specify) Widowed
8. DATE OF BIRTH 9/21/1880
9 AGE (In years last birthday) 69
If Under 1 Year Months Days
If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Hungary
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob Hagg
14 MOTHER'S MAIDEN NAME Elizabeth Knopf

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO
17 INFORMANT Johanna Lewis ADDRESS Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of pancreas with metastasis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 9/16/49
19B. MAJOR FINDINGS OF OPERATION Carcinoma of pancreas
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23A. SIGNATURE Ernest G. Cranmer M. D.
23B ADDRESS Maryland Gen'l Hosp
23C DATE SIGNED 10/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE 10/22/49
24C NAME OF CEMETERY OR CREMATORY Woodlawn Cem.
24D LOCATION (City, town, or county) (State) Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 20 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Wm. J. TICKNER & SONS
ADDRESS Balto., Md.

Vs 150

correct age is especially important. Physicians: please write the causes of death clearly, and give

Certisano

469

G79:10 ✓ No. 1 G79:10

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE FISCHER

2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3334 Richmond Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 3334 Richmond Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Mar. 17, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| unknown | Water Dept., Balto. | Baltimore, Md. | |

13. FATHER'S NAME: John Fischer

14. MOTHER'S MAIDEN NAME: Margaret Rottman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Clara Fischer | 3334 Richmond Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 2 days |
| DUE TO (B) | Arteriosclerosis generalized | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 17, 1949 *to* Oct 19, 1949, *that I last saw the deceased alive on* Oct 18, 1949, *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J. Kleiner M. D. | 2623 E. Monument St. | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/22/49 | Western Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

correct age is especially important. Physicians: please write the address where the deceased usually resided.

94a

G79:11

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4701

G79:11 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 109 BURNETT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town BALTO 23-01
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 BURNETT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. MURRAY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-16-3907

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | WIDOWER |

6 (b) Name of husband or wife EMMA Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 5, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | | | hr. min. |

9. Birthplace BALTO. Md. (Town, county, and state)
10. Usual Occupation WATCHMAN
11. Industry or business OBRECHT & LYNCH

FATHER
12. Name Edward J. MURRAY
13. Birthplace BALTO., Md.

MOTHER
14. Maiden Name SARAH SKINNER
15. Birthplace BALTO. Md.

16 (a) Informant LEO J. MURRAY
(b) Address 109 BURNETT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 20/49 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK Rd.

18 (a) Funeral director KRAUSE FUNERAL HOME
(b) Address 1216 S. CHARLES ST.

20 OCT 1949 (b) Rec'd by registrar Lexington Williams

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Oct. 18 1949 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1949 to Oct 18 1949.
and that I last saw him alive on Oct 18 1949.

Immediate cause of death: Coronary occlusion
Due to: arteriosclerosis C.V. Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

| Duration |
|---|
| |

Date of operation:
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 107 E. Wayne Date signed 10/20/49 M. D.

VS 150

93D

G79:12 ✓ G79:12

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 4-20-1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): **Rose Belle Ridenour**

2. DATE OF DEATH: **Oct. 18/49**

3. PLACE OF DEATH: A. Baltimore City, Maryland **Baltimore, Md.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **816 Woodward St.**

c. Length of stay in Baltimore: **33 Yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Md.**
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore** 21-01
D. STREET ADDRESS (If rural, give location): **816 Woodward St.**

5. SEX: **Female** 6. COLOR OR RACE: **White** 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): **Married**

8. DATE OF BIRTH: **May 3, 1895** 9. AGE (In years last birthday): **54** If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY: **Own home**

11. BIRTHPLACE (State or foreign country): **Maryland** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: **Charles Fraley**

14. MOTHER'S MAIDEN NAME: **Laura Stitley**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: **Wm. H. Ridenour, 816 Woodward St.** ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 11 1/2 hours

DUE TO

(B) Coronary Sclerosis — 7 yr

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct 17th, 1949, to Oct 18th, 1949, *that I last saw the deceased alive on* Oct 18th, 1949, *and that death occurred at* 630 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 692 Nth. Blvd

23C. DATE SIGNED: 10-20-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): **Burial**

24B. DATE: **Oct. 21/49.**

24C. NAME OF CEMETERY OR CREMATORY: **Mt. Olivet**

24D. LOCATION (City, town, or county) (State): **Frederick, Md.**

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949

REGISTRAR'S SIGNATURE: [signature] M.D.

25. FUNERAL DIRECTOR: [signature] ADDRESS: **4101 Edmondson Ave.**

VS 150

RANGE

94a

G79113 ✓ G79113

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARDING, WALTER B.

2. DATE OF DEATH: 10-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD B. COUNTY 18
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE CITY
D. STREET ADDRESS (If rural, give location): 2511 VENABLE 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| WATER HOUSEKEEPER | | Baltimore | |

13. FATHER'S NAME: Napoleon J.

14. MOTHER'S MAIDEN NAME: Selina Sue Dorsey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. M.V. Sherwood-Gilman | Apts. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: Several years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 5-11-49 | Ca of Stomach + Duodenal ulcerations | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-14 *, 19*49*, to* 10-19 *, 19*49*, that I last saw the deceased alive on* 10-19 *, 19*49*, and that death occurred at* 6:12 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Stoner M. D. | Monument & Long. | 10-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-22-49 | Druid Ridge Cem. | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Huntington Williams, M.D. | HEDEFELD & SON | GREENMOUNT AVE & 22ND |

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly.

46 B

G79:14

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

151 Registered No. G79:14

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PETER MACUIRAK

2. DATE OF DEATH October 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1431 Filbert Street

C. Length of stay in Baltimore 9 Mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-05
D. STREET ADDRESS (If rural, give location) 1431 Filbert Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | July 4, 1908 | 41 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10B. KIND OF BUSINESS OR INDUSTRY: florist

11. BIRTHPLACE (State or foreign country): Ukraine

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Macuirak

14. MOTHER'S MAIDEN NAME: Antonia Kobierska

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ervanna Macuirak ADDRESS: 1431 Filbert St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adeno carcinoma of the stomach
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Emil V Geyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Oct. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 22-1949

24C. NAME OF CEMETERY OR CREMATORY Cathederal

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2007 Eastern Ave 46B

VS 15A

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79115

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79115

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Joseph. F. Jeffres
2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6308 Everall Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 27-05
D. STREET ADDRESS (If rural, give location): 6308 Everall Ave

5. SEX: M.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 7/30/76
9. AGE (In years last birthday): 73 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Patrolman
10B. KIND OF BUSINESS OR INDUSTRY: Retired Balto Police
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Harry F. Jeffres
14. MOTHER'S MAIDEN NAME: Elizabeth Lutz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Margaret Jeffres - ADDRESS: 6308 Everall Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yr.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 8, 1948 *to* Oct. 18, 1949 *that I last saw the deceased alive on* Oct 18 1949, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Adam Stamps M. D.
23B. ADDRESS: 6232 Belair Rd
23C. DATE SIGNED: Oct. 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/22/1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Gilson Co. ADDRESS: 403 S. Wolfe St

VS 150

937

G79116 BALTIMORE CITY HEALTH DEPARTMENT G79116

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William G Miller

2. DATE OF DEATH: 10-19-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1708 Eutaw Pl — Eichhurst Nursing Home

c. Length of stay in Baltimore: Yrs. 2, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 1729 River Rd Balto Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Denis
D. STREET ADDRESS (If rural, give location): 1728 River Rd.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 25 1869
9. AGE (In years last birthday): 80
If under 1 Year: Months, Days
If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY: Balto Co Roads
11. BIRTHPLACE (State or foreign country): Balto City
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: J Miller
14. MOTHER'S MAIDEN NAME: Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Margaret J Miller 1728 River Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Cardio-vascular disease,

DUE TO

(C) arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Carcinoma - Rt. eye-lid

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 19, 1949, to Oct. 19, 1949 *that I last saw the deceased alive on* Oct 19, 1949, *and that death occurred at* 6 30 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Gauch, M. D.
23B. ADDRESS: 1700 Eutaw Place
23C. DATE SIGNED: Oct. 20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-22-49
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge
24D. LOCATION (City, town, or county) (State): Wash Blvd
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: OCT 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edward Jonson
2339 Wash Blvd 53

VS 150

G79117

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17° Registered No. G79117

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GRACE WARFIELD

2. DATE OF DEATH: 10-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 17 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Catonsville, 28.
D. STREET ADDRESS (If rural, give location): 19 Newburg Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | December 31 1899 | 49 | 9 | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Registered Nurse | — | Sylmar, Penna. | U.S.A. |

13. FATHER'S NAME: Earl Reynolds

14. MOTHER'S MAIDEN NAME: Elizabeth Coulson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No — | None | Charles D. Warfield, Catonsville 28 Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Laryngeal Edema — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
DUE TO: Metastatic
(B) Carcinoma of Lung — 2 YRS
DUE TO
(C) Carcinoma of Breast — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 1, 1949 *to* Oct 18, 1949, *that I last saw the deceased alive on* Oct 17, 1949, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Auld M. D. | Univ. Hosp. | 10-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/21/49. | West Nottingham Cemetery | Colora, Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 20 1949 | Huntington Williams, M.D. | Easton Sons, Catonsville, 28, Md. |

VS 150

50

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G79118 BALTIMORE CITY HEALTH DEPARTMENT G79118
# CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lena Greenwald
2. DATE OF DEATH: Oct. 20.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2206 Eutaw Pl.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2206 Eutaw Place.
C. Length of stay in Baltimore: 50 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 2206 Eutaw Place. 13-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hrs. / Mn. |
|---|---|---|---|---|---|---|
| F | White | Widow | June 29,1871 | 78 | 3 / 22 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Germany | |

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | Dr. Leon Greenwald | 2406 Brambleton Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute cardiac dilatation — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ____, 1934, *to* Oct. 20, 1949, *that I last saw the deceased alive on* Oct. 14, 1949, *and that death occurred at* 1A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leon L. Levy M. D. | 2206 Eutaw Place | 10/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct.21,1949 | Hebrew Friendship | Baltimore | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Huntington Williams, M.D. | Herbert Goodman Co | 1902 Eutaw Pl |

VS 150

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G79:19 G79:19

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dora Baer

2. DATE OF DEATH Oct. 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1729 Ruxton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1729 Ruxton Ave.

C. Length of stay in Baltimore 75 years. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore, Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. 15-03
D. STREET ADDRESS (If rural, give location) 1729 Ruxton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Mar. 19, 1859 | 90 | 11 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Sigfried Frisch | Mrs. Schleisner |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | Miss Lena Baer | 1729 Ruxton Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardiovascular Disease — ?

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinomatosis of Liver — 1 yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/5 19 49, *to* 10/19 19 49, *that I last saw the deceased alive on* 10/14 19 49 *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip F. Lurie M. D. | 1111 St Paul St | 10/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21, 1949 | Hebrew Friendship | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | [illegible] | 1902 Eutaw Place | David Board[illegible] |

VS 150

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BIRTH NO. 679:20

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 679:20

1. NAME OF DECEASED (Type or Print): Florence L. Williams

2. DATE OF DEATH: Oct. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 507 Charing Cross Rd.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 507 Charing Cross Rd. 28-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | Mar. 18, 1883 | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto., Md. | U.S. |

13. FATHER'S NAME: William T. Levering

14. MOTHER'S MAIDEN NAME: Cassanora Brooke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dr. Dudley Williams ADDRESS: 507 Charing Cross Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Generalized arteriosclerosis, arteriosclerotic heart disease Congestive heart failure | 9 mos |
| DUE TO (B) | Bronchopneumonia | 2 days |
| DUE TO (C) | Rheumatoid arthritis (advanced) | 10 years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 23, 1938, *to* Oct 20, 1949, *that I last saw the deceased alive on* Oct 18, 1949, *and that death occurred at* 9:50 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis P. Hamburger M.D. | 1207 Eutaw Place | Oct 21 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21, 1949 | Greenmount | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 20 1949 | Huntington Williams, M.D. | H.W. Jenkins & Sons Co. | 4905 York Rd. |

VS 150

93c

G79:21

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79:21

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances Ubellien (Ubellein)

2. DATE OF DEATH: October 19, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. Carey st.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Home
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-43
D. STREET ADDRESS (If rural, give location): 2311 Groue Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Nov. 8, 1878 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Maryland | U.S.A. |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | None | None | Catherine Causey | 2311 Groue St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis + | ? |
| DUE TO (B) | Myocardial degeneration not Rheumatic Generalized | ? |
| DUE TO (C) | Arteriosclerosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Right hemiplegia + Aphasia | 8 months |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1, 1941, *to* October, 1949, *that I last saw the deceased alive on* Oct., 1947, *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M. D. | 2030 W. Fayette St | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-22-49 | Holy Redeemer | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | George L. Schwab | 2101 Frederick Ave. |

VS 150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

679122

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679122 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas A. Howe

2. DATE OF DEATH: Oct. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 10 E. Poultney St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | married | Nov 6, 1892 | 56 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Retail Grocery | Virginia | USA |

13. FATHER'S NAME: Willie Rowe

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 213-03-7135 | Mrs Marie Rowe | 10 E. Poultney St |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO
(B) Illuminating Gas
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 10 E. Poultney St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 17, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? All burners on stove on but unlit Illuminating gas

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ (and), homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Oct. 18, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10/21/49 | Glen Haven | Glenburnie Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John F Denny Inc ADDRESS: 715 Light St

VS 151

163H

Correct age is especially important. Physicians: please write the causes of death clearly and fully. Signature, title and address must be written in full.

G79123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79123

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clara F. Keseling

2. DATE OF DEATH: 10/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4700 Harford Road

Harford Convalescent Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1241 E. Lanvale Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Oct. 27, 1863 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Missouri | |

13. FATHER'S NAME: George Keseling

14. MOTHER'S MAIDEN NAME: Mary Lauton

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|
| no | |

17. INFORMANT — ADDRESS: Bertha A. Keseling, 1241 E. Lanvale St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Renal Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/26 19 49 *to* 10/20 19 49 *that I last saw the deceased alive on* 10/19 19 49 *and that death occurred at* 1A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph D. Blum M.D. | 1115 N. Calvert St | 10/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/22/49 | Zion Cemetery | Stewartstown, Pennsylvania |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

VS 150

131a

G79124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 331

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Brooks

2. DATE OF DEATH: October 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 822 Woodbourne Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If less than 1 year, last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 2-7-1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Henry Brooks

14. MOTHER'S MAIDEN NAME: Annie Bunnie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular Accident — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-19, 1949 *to* 10-19, 1949 *that I last saw the deceased alive on* 10-19, 1949, *and that death occurred at* 10:33 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Phillip D. Nagley M. D. | JOHNS HOPKINS HOSPITAL | 10/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/24/49 | Mt. Auburn, Cem. West Port. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | Metropolitan Funeral Home Inc. | 827 27 N. Mount St. |

VS 150

correct age is especially important. Physician: please write plainly and fill in all items. Use ink.

679:25

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679:25 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GRACE MAY MOORE E-9:4.0 N-991

2. DATE OF DEATH October 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
714 Sharp Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 714 S. Sharp Street 22-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 hour: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | colored | | | | | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore City | |

13. FATHER'S NAME
David Moore

14. MOTHER'S MAIDEN NAME
Ethel Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS
Ethel Moore

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Mechanical suffocation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home in bed

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 714 S. Sharp Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 20, 1949 m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Undetermined

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23A. SIGNATURE George G. Merrill M.D.

23B CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED Oct. 20, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/21/49 | Mt Calvary Ct | A.A.Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. L. Brown & Son — ADDRESS: 108 W. Montgomery St

VS 151

182a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79:126

BIRTH NO. 4-53452

1. NAME OF DECEASED (Type or Print) Earl Robinson

2. DATE OF DEATH 10-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-02
D. STREET ADDRESS (If rural, give location) 1126 Parrish St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | Col. | | 7-30-1946 | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | — | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wilson Robinson | Augusta Jones |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | 1126 Parrish St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Asthma | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-19 19 49 *to* 10-19 19 49 *that I last saw the deceased on* 10-19 19 49 *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Bradley M. D. | Provident Hosp | 10-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/24/49 | Mt. Auburn Cem | West Nat'l Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Huntington Williams, MD | Metropolitan Funeral Home Inc | 927 N. Monroe St. |

VS 150

112

correct age is especially important. Physicians, please read carefully the instructions on the reverse side of this certificate.

79:27 ES-132506 BALTIMORE CITY HEALTH DEPARTMENT 760.5 G79:27

BIRTH NO. 49-23980 **CERTIFICATE OF DEATH** Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Baby Boy Scales ( Pauline) | 2. DATE OF DEATH: 10-14-49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY: |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto City Hospitals | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 10-02 |
| c. Length of stay in Baltimore: 4 Days (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location): 915 N. Central Avenue |
| 5. SEX: Male | 6. COLOR OR RACE: Negro |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single | 8. DATE OF BIRTH: 10-10-49 |
| 9. AGE (In years last birthday): If Under 1 Year: Months / Days: 4 | If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | 10B. KIND OF BUSINESS OR INDUSTRY: |
| 11. BIRTHPLACE (State or foreign country): Md | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: George Boyce | 14. MOTHER'S MAIDEN NAME: Pauline Scales |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): | 16. SOCIAL SECURITY NO: |
| 17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS | ADDRESS: 4940 EASTERN AVE |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Prematurety, Subarachnoid Hemorrhage. | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 10-10, 1949, *to* 10-14, 1949 *that I last saw the deceased alive on* 10-14, 1949, *and that death occurred at* 1:30 m. P *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE: C. A. Boyer M. D. | 23B. ADDRESS: 4940 EASTERN AVENUE | 23C. DATE SIGNED: 10-18-49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated | 24B. DATE: 10-18-49 | 24C. NAME OF CEMETERY OR CREMATORY: Balto City Hospitals |
| 24D. LOCATION (City, town, or county) (State): Balto. MD. | | |
| DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR / ADDRESS |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

160a

G79528

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79528

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES GUERTLER

2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2050 Harford Rd.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 2050 Harford Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | Aug. 31, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Butcher - retired | Belair Market | Baltimore, Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| FREDERICK GUERTLER | Elinore Graff |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | none | 2050 Harford Rd. 13 Mrs. Arthur H. Joslin |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Angina pectoris

DUE TO

(B) Arteriosclerosis and hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 6th, 1949, *to* Oct. 19th, 1949, *that I last saw the deceased alive on* Oct. 18th, 1949, *and that death occurred at* 3 A m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Keller White M. D. | 3005 St. Paul St. | Oct. 19th 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/22/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. |

VS 150

BALTIMORE - 13, MARYLAND 943

correct age is especially important. Physicians, please write plainly.

79:29

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 679:29

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frederick IRVING Bechtold

2. DATE OF DEATH: 10-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 13-07
D. STREET ADDRESS (If rural, give location): 4000 Roland Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | July 3, 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10B. KIND OF BUSINESS OR INDUSTRY: McMacamee

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frederick W. Bechtold

14. MOTHER'S MAIDEN NAME: Mary Schuch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT'S ADDRESS: 4000 Roland Avenue
Mrs. Mary Bechtold

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic Carcinoma c
DUE TO Sup Cerebral Metastasis ???

(B) Generalized Arteriosclerosis c
DUE TO Cerebral Thrombosis ???

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16 1949 *to* 10-20 1949, *that I last saw the deceased alive on* 10-20 1949, *and that death occurred at* 5:45 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: Univ. Hosp.

23C. DATE SIGNED: 10-20-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 10/22/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS

VS 150

BALTIMORE - 13, MARYLAND 47C

correct age is especially important. Physicians: please write the cause of death clearly and

G79:30

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 9-9.4

Registered No. G79:30

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Judy Elaine Hanlin N-990

2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Sparrows Point
D. STREET ADDRESS (If rural, give location): 1 st. Miller's Island

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | Jan. 1, 1948 | 1 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Balto. Co., Md. | |

13. FATHER'S NAME: John B. Hanlin

14. MOTHER'S MAIDEN NAME: Gladys Wolfkill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John B. Hanlin ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Drowning

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Water | Millers Island, Sparrows Point |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Oct. 19, 1949 2:45P m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Walked from beach into water, probably fell and drowned. |

22. *I certify that I took charge of the remains described above, held an* Insp. & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Oct. 20, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 21, 1949 | Oak Lawn Cemetery | Baltimore Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: 10-21-1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Roland L. Fisher, 2112 Dundalk Ave.

183

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

679:51

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679:51

BIRTH NO. | Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | AGNES JULIA JOYCE |
| 2. DATE OF DEATH | Oct. 20, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Earl Court Apts. 1301 St. Paul St. |
| c. Length of stay in Baltimore | 38 yrs. (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 11-01 |
| D. STREET ADDRESS (If rural, give location) | 1301 St. Paul St. |
| 5. SEX | Female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | June 7, 1890 |
| 9. AGE (In years last birthday) (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.) | 59 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | at home |
| 11. BIRTHPLACE (State or foreign country) | Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | - Conroy |
| 14. MOTHER'S MAIDEN NAME | Unknown |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | - |
| 16. SOCIAL SECURITY NO. | - |
| 17. INFORMANT | Mr. Hazelton A. Joyce |
| ADDRESS | Earl Ct. Apts. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 mins.

DUE TO

(B) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* June, 1947, *to* Oct. 20, 1949, *that I last saw the deceased alive on* Oct. 17, 1949, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| D. Bruce Laughlin M. D. | 4508 Edmondson Village | 10/20/49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| Burial | 10/22/49 | Christ Church Cem. | Cambridge, | Md. |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| OCT 21 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

correct age is especially important. Physicians: please write the cause of death plainly

91332

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. 67911

1. NAME OF DECEASED (Type or Print): FRANCIS CORNELIUS MYERS

2. DATE OF DEATH: 10 / 20 / 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 16-16
D. STREET ADDRESS (If rural, give location): 3040 Edmondson Ave #23

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | widowed | 2-22-1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Teacher/Private Homes | Workshop for Blind | Maryland | USA |

13. FATHER'S NAME: Cornelius Myers

14. MOTHER'S MAIDEN NAME: Mary Miller

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mrs. Mary L. Stern | 3040 Edmondson Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebrovascular accident | 4 days ± |
| DUE TO (B) | Hypertensive cardiovascular disease | ? |
| DUE TO (C) | Left hemiparesis | 4 days ± |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-15, 1949 *to* 10-20, 1949, *that I last saw the deceased alive on* 10-20, 1949, *and that death occurred at* 5° A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Cadle M.D. | Maryland General Hospital | 10 / 20 / 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10.24.49 | Parkwood Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

correct age is especially important. Physicians: please write the cause of death in terms of disease and not in terms of mode of dying, such as heart failure, asthenia, anemia, hemorrhage, uremia, etc.

927

G79133

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

'49 Registered No. G79133

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella M. Bennett
2. DATE OF DEATH: 10-18-49

3. PLACE OF DEATH
A. Baltimore City, Maryland: Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 539 N. Bond St
c. Length of stay in Baltimore: Yrs. 1 Mos. 7 Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE:
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 539 N. Bond 7-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months Days | If under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | C | Married | 10-7-1896 | 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Collison
14. MOTHER'S MAIDEN NAME: Bessie Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: George Bennett ADDRESS: 539 N. Bond St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinomatosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Carcinoma - cervix | 15 Mos. |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-9 1949 to 10-18 1949 that I last saw the deceased alive on 10-16 1949 and that death occurred at 3.10 p m., from the causes and on the date stated above.

23A. SIGNATURE: [signature]
23B. ADDRESS: 1500 EAST MADISON ST. BALTIMORE, MD.
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 21 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
FUNERAL DIRECTOR: Robert Williams
ADDRESS: 1515 McElderry St

VS 150

48a

79:34 BALTIMORE CITY HEALTH DEPARTMENT 679:34

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE Long

2. DATE OF DEATH: 10/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: University Hospital
C. Length of stay in Baltimore: Life (Yrs. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 4-03
D. STREET ADDRESS (If rural, give location): 1117 WILLIAM ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Feb. 1 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | MARYLAND | USA |

13. FATHER'S NAME: Louis Ludewig

14. MOTHER'S MAIDEN NAME: Katherine

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | | Louis Long | 1117 Wm St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | ARTERIOSCLEROTIC CARDIO-Vascular Disease | 4 YRS. |
| DUE TO (B) | Myocardial INSUFFICIENCY | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Uremia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/11, 1949, *to* 10/18, 1949, *that I last saw the deceased alive on* 10/14, 1949, *and that death occurred at* 8:49 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E Hall M. D. | University Hospital | 10/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Oct. 22/49 | MT. LIVET | FREDERICK AVE. BALTO MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | KRAUSE FUNERAL HOME | 1116 N. CHARLES ST. BALTO 30 MD |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 44 V 6729:35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

(a) Baltimore City, Maryland

(b) Street address 3721 Maymon Avenue -7-

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) 75

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Maryland (b) County —

(c) City or town Baltimore -7- (If outside city or town limits, write RURAL and give town)

28-01 (d) Street No. 3721 Maymon Avenue (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

**3 (a) FULL NAME** August Roeder, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-26-2206

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Anna J. Roeder

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr) Nov. 5, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 11 | 15 | hr. min. |

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Clerk - Credit Union

11. Industry or business Retired from Post office

MOTHER / FATHER

12. Name August Roeder

13. Birthplace Germany

MOTHER

14. Maiden Name Pauline Gephart

15. Birthplace Germany

16 (a) Informant Mrs. August Roeder

(b) Address 3721 Maymon Ave - 7-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1949 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery

Location Woodlawn, Md.

18 (a) Funeral director Miller & Amoroso

(b) Address 4510 Liberty Heights Ave.

19 (a) OCT 21 1949 (Date rec'd by registrar) Huntington Williams M.D. Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** October 20 1949 at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1949 to 10/19 1949 and that I last saw h/m alive on 10/19 1949.

Immediate cause of death Arteriosclerotic cardio vascular renal disease — Duration 10 years

Due to

Due to

Other Conditions Benign Prostatic Hypertrophy — Duration 3 years

(Include pregnancy within 3 months of death)

Date of operation 8/26/49

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Milford T. Trabaud Jr.

Address 3400 Woodbine Ave -7- Date signed 10/20/49

VS 150

121a

G79136

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79136

BIRTH NO

1. NAME OF DECEASED (Type or Print) Anna Mc Donald

2. DATE OF DEATH October 19 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2731 Eastern ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-03
D. STREET ADDRESS (If rural, give location) 2731 Eastern ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) / If under 1 Year: Months, Days / If under 24 Hours: Hours, Min. |
|---|---|---|---|---|
| F | W | Widow | 1867 | 82 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Baltimore | U.S.A. |

13. FATHER'S NAME ? Murdock

14. MOTHER'S MAIDEN NAME Mc Inman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | — | Mrs Mary Kelly Daughter | 2731 Eastern ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, R. Hyland
DUE TO Senility Generalized
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
10/19/49
10/19/49

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month, Day, Year, Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 10/18/49 *to* 10/19/49, 19 *that I last saw the deceased alive on* 10/18/49 *and that death occurred at* 11:50 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Fletcher T. Newdorm M.D. | 1876 E. Lombard | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 24/49 | New Cathedral Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Huntington Williams, M.D. | John M. Weber | 401 S. Chester st. |

VS 150

92D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679:57

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 97 r. 0 679:57 Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM L. LANCASTER — N-968

2. DATE OF DEATH October 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 546 E. Fort Avenue
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-02
D. STREET ADDRESS (If rural, give location) 546 E. Fort Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | M | 3/17/1881 | 68 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Furniture Mover | Self | Indiana | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT — ADDRESS: Family - Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO
(B) Illuminating Gas
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 546 E. Fort Avenue |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 20, 1949 9a.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Oven burner on but unlit |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Oct. 20, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 10/24/49 | Woodlawn | Woodlawn, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: James L. McCauley — ADDRESS: 130 E. Fort Ave.

163 H

VS 151

correct age is especially important. Physician: please write the cause of death clearly and legibly.

79138 ✓ 1 G79138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Marjorie L Ellis

2. DATE OF DEATH 10-19-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2622 E. Oliver St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-03
D. STREET ADDRESS (If rural, give location) 2622 E. Oliver St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 9 1881 | 68 yrs | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Compositor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maxwell Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Theodore Ellis

14. MOTHER'S MAIDEN NAME Jennie Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 213-12-4321

17. INFORMANT Emma M. Ellis ADDRESS 2622 E. Oliver St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 25 minutes

DUE TO

(B) Cardio-Vascular Renal Disease — 10 yrs

DUE TO

(C) Generalised Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4- 1939 *to* 9-10- 1949 *that I last saw the deceased alive on* 9-10- 1949 *and that death occurred at* 7.15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Milton C. Lang M. D.

23B. ADDRESS 7117 Belair Rd

23C. DATE SIGNED 10-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10-22-49

24C. NAME OF CEMETERY OR CREMATORY Baltimore Cem

24D. LOCATION (City, town, or county) Moravia Ave. Balto. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Ray E. Miller Inc.

ADDRESS 2435 E. Oliver St

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

131a

G79139

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 4-20-W Registered No. G79139

1. NAME OF DECEASED (Type or Print): Leona E. Muth

2. DATE OF DEATH: 10/19/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland Baltimore, Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 218 E. University Parkway

c. Length of stay in Baltimore: About 75 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
d. STREET ADDRESS (If rural, give location): 218 E. University Parkway

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: about
9. AGE (In years last birthday): 75 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles A. Decker
14. MOTHER'S MAIDEN NAME: Theresa Isabel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Donald W. Muth ADDRESS: Odenton, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Angina Pectoris — INTERVAL BETWEEN ONSET AND DEATH: 4 attacks in past 10 days -
DUE TO
(B) General Arterio Sclerosis 10 yrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 10 '49 *to* Oct. 19 '49 *that I last saw the deceased alive on* Oct 19, 1949 *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Leona E. Muth
23b. ADDRESS: 2 W. Biddle St.
23c. DATE SIGNED: Oct. 21, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/22/49
24c. NAME OF CEMETERY OR CREMATORY: New Cathedral
24d. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Bell Undertaking Co. ADDRESS: 605 W. Calvert St.

VS 150

948

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:40 ✓ No. 1 G79:40

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES H. SCUDDER.

2. DATE OF DEATH: Oct 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3114 Kennick Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 12-15
D. STREET ADDRESS (If rural, give location): 3114 Kennick Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months: Days | If Under 24 Hours: Hours: Min. |
|---|---|---|---|---|---|---|
| Male | White | Married. | Sept 9, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Refrigerator Mech. | Carlin Park. | Florida. | |

13. FATHER'S NAME: Charles E. Scudder.

14. MOTHER'S MAIDEN NAME: Hortense Glover.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes 1st W. W. | 077-01-7692 | Mildred L. Scudder. | 3114 Kennick Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 10/17/49 |
| DUE TO (B) | Chr. Myocarditis | 1947 |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 17, 1949, *to* Oct 17, 1949, *that I last saw the deceased alive on* Oct 17, 1949, *and that death occurred at* 1930 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Brown | 1630 North Ave | 10/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/22/49 | Lorraine Park. | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Lucinda Williams, M.D. | Paul E. Chenoweth Jr. | 3615-17 Chestnut Ave. |

VS 150

(over)

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

937

679141 CERTIFICATE CORRECTED 11-7-49 X 679141

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4201

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): EMILY JOHNSON | 2. DATE OF DEATH: OCTOBER 21 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Pennsylvania |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6015 York Rd | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore New Castle |
| c. Length of stay in Baltimore: Yrs. 6 Mos. Days | D. STREET ADDRESS (If rural, give location): 6015 York Rd. 406 Laurel Blvd. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Single | 1-13-1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | | PENNA. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| EDWIN A. JOHNSON | MARY ANNE STRAWN |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | MRS C. Lee MELLINGER not LAUREL BLVD NEW CASTLE, PA. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Coronary arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October 17, 1949, *to* October 21, 1949 *that I last saw the deceased alive on* October 21 1949, *and that death occurred at* 9:15 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frederick J. Vollmer M. D. | 6100 York Road | Oct 21 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-24-49 | CASTLE VIEW MEMORIAL PARK | NEW CASTLE PENNA. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 21 1949 | Contractor Williams, M.D. | John A. Moran 3000 Balto St. |

94a

Correct age is especially important. Physician: please write plainly.

BIRTH NO. G79142

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79142

1. NAME OF DECEASED (Type or Print): Preston ADell Kidwell

2. DATE OF DEATH: OCT 20 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 2527 Lodge Forrest Drive

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-9-1905
AGE (In years last birthday): 44
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: George Kidwell
14. MOTHER'S MAIDEN NAME: Mary Kidwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 Y2 wks

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B) arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) ? hypertension

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-25-1949 *to* 10-20-1949, *that I last saw the deceased alive on* 10-20-1949, *and that death occurred at* 1145 *m., from the causes and on the date stated above.*

23A. SIGNATURE: William W. Wiserman M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/23/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Crest
24D. LOCATION (City, town, or county) (State): Alexandria - Va.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Hunterton Williams, M.D.

25. FUNERAL DIRECTOR: Lilly & Jeter — ADDRESS: 403 S. Wolfe St.

94a

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G79143

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G79143

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATHERINE M. BAYER

2. DATE OF DEATH: Oct. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2846 W. North Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2846 W. North Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | April 16, 1869 | 80 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Baltimore, Md. | |

13. FATHER'S NAME: * Karmrodt

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | none | Mrs. Mildred Koehler - 4111 Milford Mill Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | Immediate death |
| DUE TO (B) | Arteriosclerosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June, 1929 *to* Oct 18, 1949 *that I last saw the deceased alive on* Oct 18, 1949, *and that death occurred at* 4.30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J Edw Talbot M. D. | 2723 St Paul St | Oct 21 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/21/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 21 1949 | Huntington for Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

VS 150

correct age is especially important. Physician: please write the cause of death clearly and legibly.

83a

G79:44 ✓ × 80.1 G79:44

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas Tomlinson

2. DATE OF DEATH October 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middle River
D. STREET ADDRESS (If rural, give location) 128 B. Popular Rd., Route 13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | ?-?-04 | 45 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asp Craft
10B. KIND OF BUSINESS OR INDUSTRY Glenn L. Martin Co
11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John C. Tomlinson
14. MOTHER'S MAIDEN NAME Ida Mary Shaw ✓
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory paralysis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO
(B) Ascending polyneuritis
DUE TO
(C) poliomyelitis (onset)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17, 1949, *to* 10-18, 1949 *that I last saw the deceased alive on* 10-18, 1949, *and that death occurred at* 3:30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Joseph D. Dr. King M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 10-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 22-49
24C. NAME OF CEMETERY OR CREMATORY Berlin Cemetery
24D. LOCATION (City, town, or county) (State) Berlin New Jersey

DATE RECEIVED BY LOCAL REGISTRAR OCT 21 1949
REGISTRAR'S SIGNATURE Washington Williams, M.D.
25. FUNERAL DIRECTOR John G. Connelly ADDRESS 418 Eastern Ave. Balto. 21, Md.

VS 150

36

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79145

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 59

G79145 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOUISE C. PIZZUTELLI
2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 1008 Fawn St. Apt #2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 10/1/04 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | Home | Baltimore Md. | U.S. |

13. FATHER'S NAME: John Berterelli
14. MOTHER'S MAIDEN NAME: Angela Speroni

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Joseph F. Pizzutelli | 1008 Fawn St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic (nephritis)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 10/4 1949 to 10/21, 1949 that I last saw the deceased alive on 10/21, 1949, and that death occurred at 6 45 Am., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles F. Blank M. D. | Maryland General | 10/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 24 1949 | Holy Redeemer Cemetery | 4430 Belair Rd. Balt. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams M.D. | Frank Dillon Noel | 322 S. High St. |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1316

BIRTH NO. 79146

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 79146

1. NAME OF DECEASED (Type or Print): Etta M. Flynn
2. DATE OF DEATH: 10-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 3 weeks (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.Y.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Syracuse N.Y.
D. STREET ADDRESS (If rural, give location): 406 Lafayette Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | married | about 65 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Brockville Canada | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John McIntyre | Elizabeth Loftus |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Harry W. Flynn | 7013 Wallace Balto. Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Heart Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertherapedism | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-15, 1949, *to* 10-20, 1949, *that I last saw the deceased alive on* 10-20, 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerome Gaber M. D. | Sinai Hosp. | 10-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 24-49 | St. Agnes | Syracuse N.Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 21 1949 | Thurston Williams, M.D. | Frank H. Newell | Pikesville Md. |

VS 150

6262

correct age is especially important. Physicians: please write the causes of death plainly.

G79147

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79147 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minna Dressman Starr

2. DATE OF DEATH: Oct 20 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home
c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4809 Roland Ave 27-14

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: May-25-1869
9. AGE (In years last birthday): 80 yrs
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John D Starr
14. MOTHER'S MAIDEN NAME: Minna Crozall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs Agnes Bayley-sister
ADDRESS: Balto

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Edema
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: —

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from 2-14 1949, to 10-20 1949, that I last saw the deceased alive on 10-20 1949, and that death occurred at 9 AM m., from the causes and on the date stated above.

23A. SIGNATURE: William J Wolfrecht M.D.
23B. ADDRESS: 5806 Roland Ave
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct-22/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Hunter Jr Williams, M.D.
25. FUNERAL DIRECTOR: Stewart-Morris Co.
ADDRESS: Balto

VS 150

111 C

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79148 X G79148

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. 73.1 Registered No.

1. NAME OF DECEASED (Type or Print) Naomi C. Dibb

2. DATE OF DEATH Oct. 21, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables
c. Length of stay in Baltimore 7 Yrs. 10 Mos. 5 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bel Air R.F.D. #2
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months, Days | If Under 24 Hours Hours, Min. |
|---|---|---|---|---|---|---|
| Female | white | single | Sept 21, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | no | Bel Air, Harford Co., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Thomas Dibb | Lottie Virginia Hutson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | M. F. Owens | Home for Incurables |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Myocardial Insufficiency | (Sudden) a few minutes |
| DUE TO | Arteriosclerotic Cardio Vasc. Dis. | a few years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Gross Multiple Arthritic Deformities | since 1935 |
| DUE TO | ? | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Secondary Anemia | Since 1945 |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 13th, 1941, *to* Oct. 21st, 1949, *that I last saw the deceased alive on* October, 1949, *and that death occurred at* 5.55 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Conrad Wolf M.D. | 11 E. Chase St. Baltimore 2. Md. | Oct. 21st 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/22/49 | Mt. Zion Cem. | Harford Co., Md. |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto. Md. |

VS 150

correct age is especially important. Physicians: please write the

93 c

G79149 ✓ BALTIMORE CITY HEALTH DEPARTMENT 43 G79149

BIRTH NO.

# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): FRANCES ADDERSON

2. DATE OF DEATH: 21 Oct 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hosp.

c. Length of stay in Baltimore: 5 Mo. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: A. A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annapolis. Md.
D. STREET ADDRESS (If rural, give location): monument St. Annapolis

5. SEX: Fem.
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Feb 1876
9. AGE (In years last birthday): 72. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): A. A. Co
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Harris
14. MOTHER'S MAIDEN NAME: Eliza Giles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Eliza Carpenter ADDRESS: 619 E. Carey Baltimore

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B) Arteriosclerotic + hypertensive cardio-vascular disease with cerebral + myocardial degeneration
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Varicose ulcerations, both legs + feet

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 June, 1949 *to* 21 Oct, 1949, *that I last saw the deceased alive on* 21 Oct, 1949, *and that death occurred at* 11.20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil H Henning Jr M. D.
23B. ADDRESS: 4580 Edmondson Ave
23C. DATE SIGNED: 21 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 25 1949
24C. NAME OF CEMETERY OR CREMATORY: Brewer Hill
24D. LOCATION (City, town, or county) (State): Annapolis Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: J. B. Johnson ADDRESS: Annapolis

VS 150

93D

correct age is especially important. Physicians: please write the causes in terms understandable to lay readers.

G79150 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 — Registered No. G79150

1. NAME OF DECEASED (Type or Print): Eva Theresa Holmes
2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 707 N. Fanvale St.
C. Length of stay in Baltimore: Yrs. 17 Mos. 03 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 707 N. Fanvale St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Married | Aug. 2, 1885 | 64 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Norfolk Va | U.S.A. |

13. FATHER'S NAME: Benjamin Roberts
14. MOTHER'S MAIDEN NAME: Hattie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Jessie Holmes | 707 N. Fanvale St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 76-14-49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — Prolonged

DUE TO

(C) Hypertension — Prolonged

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-14, 1949 *to* 10-18, 1949 *that I last saw the deceased alive on* 10-18, 1949, *and that death occurred at* 6:30 P.M., *from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles Wardell M. D. | 861 Madison Ave | 10-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 22, 1949 | Loudon Park Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 22 1949 | Registrar Williams, M.D. | Holland Funeral Home | 1621 Druid Hill Ave. 83a |

VS 150

correct age is especially important. Physicians: please write the entries on this certificate legibly.

BIRTH NO. 379:51

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 379:51

1. NAME OF DECEASED (Type or Print) ADELAIDE FLEETWOOD YOUNG 430.1

2. DATE OF DEATH October 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-02
D. STREET ADDRESS (If rural, give location) 1334 Shields Place

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | married | July 3, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| domestic | | | |

13. FATHER'S NAME: Moses Fleetwood

14. MOTHER'S MAIDEN NAME: Sophia Ward

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Joseph Fleetwood | 1115 Myrtle Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure

DUE TO

(B) Aortic Stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Kaye M.D. | | Oct. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-22-1949 | Mt. Olivet Cemetery | B. C. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 22 1949 | Remington for Williams, M.D. | William H. Jackson | 916 Penna. Ave. |

VS 151

92a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79152 G79152

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Yr. 1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mina Evelyn Knight

2. DATE OF DEATH: 10-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14 27-01
D. STREET ADDRESS (If rural, give location): 3301 Moravia Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 11-24-98 | 50 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ryer

14. MOTHER'S MAIDEN NAME: Joanna Metz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: JAMES R. DAVIS ADDRESS: 3301 MORAVIA

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: ± 5 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular Disease + 2 yrs

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Obesity

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 10-21 , 1949 *to* 10-21-1949 , *that I last saw the deceased alive on* 10-21 , 1949 , *and that death occurred at* 7:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE, M.D.: [signature]

23B. ADDRESS: 2843 St Paul St.

23C. DATE SIGNED: 21 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

24B. DATE: 10/22/49

24C. NAME OF CEMETERY OR CREMATORY: FOREST LAWN.

24D. LOCATION (City, town, or county) (State): NORFOLK VA

DATE RECEIVED BY LOCAL REGISTRAR: OCT 22 1949

REGISTRAR'S SIGNATURE: [signature]

25. FUNERAL DIRECTOR: Ulrich Funeral Home ADDRESS: 2307 Eastern

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G79153 — 772.0 — Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Eva Smith Finney | 2. DATE OF DEATH: October 20, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland 33 York Court | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: none |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01 |
| c. Length of stay in Baltimore: 32 Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location): 33 York Court |
| 5. SEX: female | 6. COLOR OR RACE: white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married | 8. DATE OF BIRTH: |
| 9. AGE (In years last birthday): 67 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY: |
| 11. BIRTHPLACE (State or foreign country): Bel Air, Maryland | 12. CITIZEN OF WHAT COUNTRY? U. S. |
| 13. FATHER'S NAME: Benjamin Smith, M. D. | 14. MOTHER'S MAIDEN NAME: Lucy W. Wilson |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO: |
| 17. INFORMANT: Walter Finney | ADDRESS: 33 York Court, Baltimore |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Psoriasis | 30 yrs. |
| | DUE TO Rheumatoid Arthritis | 30 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* August 1, 1949, *to* Oct. 20, 1949, *that I last saw the deceased alive on* Oct. 19, 1949, *and that death occurred at* 6:00 A.m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE: Conrad N. Kirkpatrick, Jr. M. D. | 23B. ADDRESS: 6 E. Eager St. | 23C. DATE SIGNED: Oct. 22, 1949 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 10/22/49 | 24C. NAME OF CEMETERY OR CREMATORY: Churchville |
| 24D. LOCATION (City, town, or county) (State): Churchville, Maryland | | |
| DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949 | REGISTRAR'S SIGNATURE: Hunter for Mitchell | 25 FUNERAL DIRECTOR AND ADDRESS: John O. Mitchell & Sons, Inc. - 1900 Eutaw Pl. Walton B. Mitchell 59a |

VS 150

Physicians: please write the causes of death clearly and accurately. Correct age is especially important.

G79154

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153

G79154

Registered No.

1. NAME OF DECEASED (Type or Print): EDGAR KREATSCHMAN

2. DATE OF DEATH: 10/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 1425 N. Fayette St.

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Sept. 16, 1880
9. AGE (In years last birthday): 69 yrs. If Under 1 Year: Months Days. If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY: Store Fixtures

11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Adolph F. Kreatschman

14. MOTHER'S MAIDEN NAME: Mollie Schultz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-8155A

17. INFORMANT: Mrs. Elsa A. Glaser ADDRESS: 42 S. Morley St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinomatosis | ? |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Carcinoma of sigmoid | ? |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) pulmonary embolism? | few hours |

19A. DATE OF OPERATION: 9/16/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma sigmoid with metastasis to liver
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/10, 1949 *to* 10/20, 1949 *that I last saw the deceased alive on* 10/17, 1949, *and that death occurred at* 7:15 P m. 10/20/49, *from the causes and on the date stated above.*

23A. SIGNATURE: J R Hankins M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 10/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/24/49
24C. NAME OF CEMETERY OR CREMATORY: Immanuel Lutheran Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: 10/24
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

46E

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G79155

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 577

G79155

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Mae Laird

2. DATE OF DEATH: Oct. 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General

C. Length of stay in Baltimore: 2 days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md 10-01
D. STREET ADDRESS (If rural, give location): 839 S. Clarse Sheet

5. SEX: F. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married | 8. DATE OF BIRTH: Aug. 29-99 | 9. AGE (In years last birthday): 50 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife | 10B. KIND OF BUSINESS OR INDUSTRY: Home | 11. BIRTHPLACE (State or foreign country): Somerset Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown | 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ✓ | (If yes, give war or dates of service) ✓ | 16. SOCIAL SECURITY NO ✓ | 17. INFORMANT: Hallie Laird — ADDRESS: 839 S. Clarse St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Perforation of Ileum
DUE TO
(C) Typhoid Fever

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 17 Oct. 49 | 19B. MAJOR FINDINGS OF OPERATION: Intraabdominal Peritonitis | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 Oct., 1949, *to* 21 Oct., 1949, *that I last saw the deceased, alive on* 21 Oct., 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Morrow M. D. | 23B. ADDRESS: West Baltimore General Hosp. | 23C. DATE SIGNED: 21 Oct. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 10/25/49 | 24C. NAME OF CEMETERY OR CREMATORY: Rodgers Point | 24D. LOCATION (City, town, or county) (State): Somerset Co. - Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Lilly & Zeiler Inc. | ADDRESS: Balto. Md.

VS 150

129

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79156

1. NAME OF DECEASED (Type or Print): ROBERT CALLOWAY

2. DATE OF DEATH: October 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 934 Druid Hill Avenue 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | married | Nov. 3. 1899 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Bedford Co. Va
12. CITIZEN OF — WHAT COUNTRY?

13. FATHER'S NAME: Robert Calloway
14. MOTHER'S MAIDEN NAME: Lucinda Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
C. SOCIAL SECURITY NO
17. INFORMANT: Mr James Calloway. 1014 Pierce ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pericardial hemorrhage,

DUE TO

(B) due to rupture of aneurysm of aorta.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Thos G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 10-19-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 22-1949 | Mt. Calvary | Balto. Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Earl Fillmore ADDRESS: 519 Mosher St.

VS 151 49629

30D

G79157 ✓ G79157

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): **Mary E. Gains**

2. DATE OF DEATH: **Oct. 22, 1949**

3. PLACE OF DEATH:
A. Baltimore City, Maryland **3010 N. Calvert St.**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: **42 years** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore** 12-02
D. STREET ADDRESS (If rural, give location): **3010 N. Calvert St.**

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| **Female** | **White** | **Widowed** | **Feb. 20, 1867** | **82** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **Housewife** | | **Maryland** | **U.S.A.** |

13. FATHER'S NAME: **Andrew J. deLashmutt**

14. MOTHER'S MAIDEN NAME: **Phoebe Reich**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| **No** | **None** | **Miss Helen Gains** | **3010 N. Calvert St. Baltimore, Md.** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) **Hypertensive Cardiovascular Renal disease** | **15 yrs.** |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* **Sept. 12**, 1949, *to* **Oct. 22**, 1949, *that I last saw the deceased alive on* **Oct. 21**, 1949, *and that death occurred at* **2:45A** *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **Lloyd E. Taylor** M. D. | **3902 Greenmount Ave** | **Oct 22, 1949** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Oct. 24, 1949** | **Mt. Olivet Cemetery** | **Frederick Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT | **Lemuel Williams, M.D.** | **C.E. Cline & Son** | **Frederick, Md.** |

VS 150

correct age is especially important. Physicians: please write the cause of death plainly.

121a

G79158

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79158

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Bish — 57

2. DATE OF DEATH: Oct 21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 718 Aliceanna St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-03

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 718 Aliceanna

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | July | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Lithuania | |

13. FATHER'S NAME: Louis Matuk

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | John Bish | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Hemorrhage, Gastro Intestinal | 2 days |
| DUE TO | | |
| (B) | Ruptured Esophageal Vein | 2 days |
| DUE TO | | |
| (C) | Carcinoma of Pancreas | 7 mo. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 1949 | Carcinoma of Pancreas | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 1949 *to* Oct 1949, *that I last saw the deceased alive on* Oct 21, 1949, *and that death occurred at* 5:50 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clarence W. LeRoux M. D. | 3023 Eastern Ave | 10-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Oct 24 49 | Holy Rosary | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | Fred W. Ozarowski | 1900 Eastern Ave 469 |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679:59 ✓ 679:59

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. E81,210

1. NAME OF DECEASED (Type or Print): Gilbert Deshner N-833

2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joesph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 141 S. East Ave. 26-10

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept. 28, 1941
9. AGE (In years last birthday): 8 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Earl Deshner
14. MOTHER'S MAIDEN NAME: Audrey C.Elgin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Earl Deshner ADDRESS: 141 S.East Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Pratt & Bouldin Sts. 26/10
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 19, 1949 3:15 P. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by Balto. Transit Work Truck

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Kaye M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Oct. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/22/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Taylor Ave.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR
25. FUNERAL DIRECTOR: Clarence F.Hoffmann ADDRESS: 1638 Broadway.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

170c

G79:60 ✓ G79:60

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 1

1. NAME OF DECEASED (Type or Print): E. PEERCE SMITH

2. DATE OF DEATH: 10/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 28-02
D. STREET ADDRESS (If rural, give location): 3303 Hillsdale Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | Mar. 15, 1891 | 58 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| President | Floor Covering | Maryland | |

13. FATHER'S NAME: William F. Smith

14. MOTHER'S MAIDEN NAME: Lelia Weishampel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | |

17. INFORMANT: Mrs. Florence C. Smith — ADDRESS: 3303 HillsdaleRd

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dropsy Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| P. F. Sullivan M.D. | | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/24/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 22 1949 | Registrar for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

94a

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

679:1:1

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 977.0 679:1:1

BIRTH NO.

Registered No. N-874.2

1. NAME OF DECEASED (Type or Print): George Francis Malone

2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3906 Juniper Rd
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3906 Juniper Rd 12-01

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 13, 1868
9. AGE (In years last birthday): 81
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Car Service
10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Malone

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. O. L. Andrews ADDRESS: Birmingham, Mich.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Exsanguination - Incised Wound Jugular Vein
DUE TO
(B) Carcinoma Parotid (Rt) Gland
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): at home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3906 Juniper Rd
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 10/21/49 1PM
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Cut throat & razor blade

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

23A. SIGNATURE: C. J. Lubrinsky M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 10/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10.24.49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 22 1949
REGISTRAR'S SIGNATURE: [illegible] Baltimore, Md.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

H64D

VS 151

Please write clearly with ink. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79162 ✓ X G79162

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Otis Dotson — Jr. ?

2. DATE OF DEATH: 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ft Detrick Rt #3
D. STREET ADDRESS (If rural, give location): Rt #3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | B | Infant | 2-49 | | 9 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Stanley Dotson

14. MOTHER'S MAIDEN NAME: Hazel Jones

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal insufficiency — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) unknown — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: atelectasis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8-30 , 1949 *to* 10-22 , 1949, *that I last saw the deceased alive on* 10-22 , 1949, *and that death occurred at* 11 28 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. J. Brandes M.D. | University Hosp | 10-22 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 24 1949 | Woodsville | Frederick Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | C. M. Walty | Winfield, Md. |

VS 150

1330

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79163 ✓ G79163

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 141

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John Hugh Fallin

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): United States Marine Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days: one month ten days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 26, 1891 | 57 | 1 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Taxi driver | Taxi | Virginia | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Fallin | Nannie Paine |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | WWI | | Virginia Fallin | 1300 Sussex Pl. Va. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of tongue, local extension | 10 mos. |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 1949 | Carcinoma of tongue | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 22, 1949 *to* Oct. 22, 1949 *that I last saw the deceased alive on* Oct 22, 1949, *and that death occurred at* 1 51 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James M. Severson M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| REMOVAL | OCT. 23, 1949 | | NORFOLK, VIRGINIA. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 23 1949 | Huntington Williams M.D. | WILLIAM J. TICKNER & SONS, BALTO., MD. | |

VS 150

Severson 45B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. G79164

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79162

1. NAME OF DECEASED (Type or Print): BESSIE ELLISON 171

2. DATE OF DEATH: Oct. 21 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4405 GARRISON BLVD
c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO 15-10
D. STREET ADDRESS (If rural, give location): 4405 GARRISON BLVD

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: JUNE 15, 1900
9. AGE (In years last birthday): 49 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: NATHAN GORDON
14. MOTHER'S MAIDEN NAME: TILLIE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: RAYMOND KERCHEM - ADDRESS: 4405 GARRISON BLVD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of cervix — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(B) none
DUE TO
(C) none

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: July 24, 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of cervix
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 1949, to Oct 21, 1949 *that I last saw the deceased alive on* Oct. 21, 1949, *and that death occurred at* 11:25 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis V. Blum M.D. M. D.
23B. ADDRESS: 2310 Eutaw Pl
23C. DATE SIGNED: 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-23-49
24C. NAME OF CEMETERY OR CREMATORY: HEBREW FRIENDSHIP
24D. LOCATION (City, town, or county) (State): BALTO. MD

DATE RECEIVED BY LOCAL REGISTRAR: OCT 23 1949
REGISTRAR'S SIGNATURE: Emmanuel Willigmus M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc. ADDRESS: 2100 Eutaw Pl.

VS 150

48a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. G79165

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79165

1. NAME OF DECEASED (Type or Print): MARY CHOR

2. DATE OF DEATH: 10-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 60 Yrs. ~~Mos.~~ ~~Days.~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2133 Linden Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 77
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Moses
14. MOTHER'S MAIDEN NAME: Hattie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Leon Chor ADDRESS: 4302 Ethland Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4, 1949 *to* 10-21, 1949 *that I last saw the deceased alive on* 10-21, 1949, *and that death occurred at* 9 4 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Katz M. D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-23-49
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79166 CERTIFICATE CORRECTED 11/17/49 ✓

BALTIMORE CITY HEALTH DEPARTMENT 43 G79166

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ANNA BERGER

2. DATE OF DEATH Oct 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto Gen. Hospital

c. Length of stay in Baltimore Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 24-01

D. STREET ADDRESS (If rural, give location) 3502 Virginia Av.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | married | | (64) 62 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Poland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob

14. MOTHER'S MAIDEN NAME Minnie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Hans Berger ADDRESS 3502 Virginia Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 hours

DUE TO

(B) Hypertensive Arteriosclerotic Cardiovascular disease — unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 19, 1949, to Oct 20, 1949, *that I last saw the deceased alive on* Oct 19, 1949, *and that death occurred at* 7:05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph Shear M. D. | WBGH | Oct 20 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-23-49 | United Hebrew | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 23 1949 | Thurlington Williams, M.D. | Jack Lewis Jr. | 2100 Eutaw Pl |

VS 150

939

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

BIRTH NO. H-10 298

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Bernard B. Savage

2. DATE OF DEATH: Oct. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 1138 Russell St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Child | Sept. 26, 1944 | 5 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Boykin
14. MOTHER'S MAIDEN NAME: Reva Savage
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Reva Savage ADDRESS: 1138 Russell Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed Chest — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Cross and Russell Sts., Balto., Md.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 20, 1949 12:20 P. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by trailer truck 21/1

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil L. Hoyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Oct. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/23/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn A.A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 23 1949
REGISTRAR'S SIGNATURE: Contrington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave.

VS 151

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Cause of age is especially important.

170C

G73108 ✓ G73108

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 00

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kate Rebecca Young

2. DATE OF DEATH: 10/20/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 253 North Exeter St

c. Length of stay in Baltimore: 10 Months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): 253 North Exeter St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Single | 5/6/1927 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Private | Blackstone Virginia | U.S.A. |

13. FATHER'S NAME: Willie Young

14. MOTHER'S MAIDEN NAME: Mattie Love

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Mattie Holden 253 N. Exeter St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5. 20 , 1949 *to* 10. 20. 49, 19 , *that I last saw the deceased alive on* 10. 20, 1949, *and that death occurred at* 6.15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. L. Berry M. D. | 1420 E. Chase | 10. 22. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 24. 1949 | Mt Calvery Cem. | Brooklyn A.A.Co.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 28 1949 | | Elroy O. Wilson 1000 Brantly Ave |

Huntington Williams, M.D.

150

13 C

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G79369 — BALTIMORE CITY HEALTH DEPARTMENT — G79369

# CERTIFICATE OF DEATH

43-4.3 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAY M. BELL

2. DATE OF DEATH: Oct. 22-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — BALTO. MD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOUR HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
5112 HARFORD RD.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. MD. 27-03
D. STREET ADDRESS (If rural, give location): 5112 Harford Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Apr. 28-1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Accountant | Bethlehem Steel | Johnstown, Pa | |

13. FATHER'S NAME: John Bell

14. MOTHER'S MAIDEN NAME: Minnie E Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 213-07-1750

17. INFORMANT: Joseph H. Bell — ADDRESS: 3714 Echodale Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs.

DUE TO

(B) Chronic cor pulmonale

DUE TO

(C) Massive pulmonary emphysema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 19, 1949 *to* Oct. 22, 1949 *that I last saw the deceased alive on* Oct. 21, 1949, *and that death occurred at* 6:50 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul G. Mannino, M. D. | Bon Secours Hosp. | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/25/49 | Parkwood | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 23 1949

REGISTRAR'S SIGNATURE: Thurston for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Leonard J Ruck 5305 Harford Rd

95c

4S 150

Please write plainly with pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure that the age is especially important.

G79170 ✓ 490X G79170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances C. Jenkins

2. DATE OF DEATH: 10/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 117 E. Cross St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-03
D. STREET ADDRESS (If rural, give location): 117 E. Cross St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | June 5 - 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Balto Md | |

13. FATHER'S NAME: Frederick Hersick

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Wm Jenkins ADDRESS: 5403 Hillsboro

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia (Bilateral) — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) —

DUE TO

(C) —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Acute cardiac failure — 1 day

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 9, 1949 *to* Oct 20, 1949 *that I last saw the deceased alive on* Oct 20, 1949, *and that death occurred at* 7.45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr L Barranco M. D. | 736 E Dart ave | 10/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 10/24/49 | Baltimore | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 23 1949 | Huntington Williams, M.D. | Leonard J. Luck - 5305 | Harford Rd |

VS 150

108

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly. Information is especially important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

Dr J. J. Davis Med Arts 79171

CERTIFICATE CORRECTED 10-31-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4/20.1 G79171 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Andrew Furletti Sr.

2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5412 Catalpha Road

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 5412 Catalpha Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | Nov 4 1890 | 58 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Marble Cutter | Retired | Italy | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Laura Furletti - 5412 Catalpha |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from June 1946 to Oct 21, 1949 that I last saw the deceased alive on Oct 21 1949 and that death occurred at 7:45 A.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John R Davis M. D. | 21 (Med Arts Building) | 10/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/24/49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 23 1949 | Kathryn Williams, M.D. | Leonard J. Luck | 5305 Harford Rd. |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79:72 — BIRTH NO. 48-05931 — 053.1 — G79:72 — Registered No.

1. NAME OF DECEASED (Type or Print): MICHAEL FRANCIS LEIPOLD

2. DATE OF DEATH: October 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-03
D. STREET ADDRESS (If rural, give location): 3209 Lake Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: Mar. 14-
9. AGE (In years last birthday): 1 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): BalTo MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John T. Leipold Jr.
14. MOTHER'S MAIDEN NAME: MARILYN A. SERRA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr John T. Leipold — ADDRESS: 3209 Lake

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia - probably due to Staphylococcus.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: R. S. Fisher, M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/24/49
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's (Govans)
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 23 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Leonard Ruck — ADDRESS: 5305 Harford

24a

VS 151

READ WHITE FOR ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79173 G79173

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. 171 Registered No.

1. NAME OF DECEASED (Type or Print): SHIFFLETT, VIRGIE
2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTO.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 1-04
D. STREET ADDRESS (If rural, give location): 231 N. CHAPEL ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | APR 10, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AT HOME | | VIRGINIA | |

13. FATHER'S NAME: ACIE SHIFFLET
14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | JAMES SHIFFLET | 231 N. CHAPEL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of cervix - recurrent and retentive | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | SUB ARACHNOID HEM. - PARTIAL BONEL OBST. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NONE | NONE | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 10/21, 19 49 *and that death occurred at* 11 30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul C. Vernon, M. D. | SINAI HOSP. | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Oct 23/49 | | ELKTON VA. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 23 1949 | Huntington Williams, M.D. | Veltri Funeral Home | 2008 Orleans |

48a

If correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:'74

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4-20

G79:'74

Registered No.

1. NAME OF DECEASED (Type or Print): Bridget Julia Ormond

2. DATE OF DEATH: Oct. 21/49 PM.

3. PLACE OF DEATH: A. Baltimore City, Maryland 1431 Poplar Grove St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 81 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 1431 Poplar Grove St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan 24 1864
9. AGE (In years last birthday): 85 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Waterford Island
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis M. Ormond
14. MOTHER'S MAIDEN NAME: Julia L. Crowly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (ADDRESS): Mrs Marie B. Mondlehan 1431 Poplar

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction
DUE TO
(B) Generalized arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Carcinoma, stomach

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/17, 1949, *to* 10/21, 1949 *that I last saw the deceased alive on* 10/21, 1949, *and that death occurred at* 1:25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: James J. Wilson M. D.
23B. ADDRESS: 5804 Edmondson Ave, Balto 28
23C. DATE SIGNED: 10/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 24/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Loring Byers ADDRESS: 5005 Ph. Hyttenberg

VS 150

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

46B

G79175

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1944

Registered No. G79175

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY R. Ridgely

2. DATE OF DEATH October 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 501 E. 35th St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 9-03
D STREET ADDRESS (If rural, give location) 501 E 35th Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | W. Jowed | Sept 29, 1848 | 101 Yrs 13 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housekeeper | own home | Balto. Co. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Andrew McA. Dow | Sarah (McA. Dow) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | | MRS. Alice Ferrens |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senility
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October 22 1949 *to* _____, 19__, *that I last saw the deceased alive on* Oct. 22, 1949, *and that death occurred at* 9.15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin M. Borden M. D. | 2030 W. Fayette St | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/24/49 | Lorraine | Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | Wm Cook Inc. 1217 St. Paul St. |

VS 150

162B

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

679176

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

150

679176

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Henry W. Yearly

2. DATE OF DEATH Oct. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY —

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore 15 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1720 St. Paul St. 12-05

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept 12 1884 Unknown

9. AGE (In years last birthday) 65 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter

10B. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Massachusetts

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unknown

17. INFORMANT Discard ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

DUE TO

(B) Oesophageal Stenosis 4 mos

DUE TO

(C) Carcinoma of Oesophagus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1, 1949, *to* Oct. 10, 1949 *that I last saw the deceased alive on* Oct. 9, 1949, *and that death occurred at* 5:05 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas A. Cline M.D.

23B. ADDRESS Mercy Hospital

23C. DATE SIGNED Oct. 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10/24/49

24C. NAME OF CEMETERY OR CREMATORY St. Peters

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm. Bok Inc. ADDRESS 217 St. Paul St.

VS 150

46a

Please see that correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:77

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-14382 — Registered No. 5710 — G79:77

1. NAME OF DECEASED (Type or Print): Rudolph Insley

2. DATE OF DEATH: 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 3 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md
D. STREET ADDRESS (If rural, give location): 630 Portland st 22-12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 7/7/44 | | 3 | 15 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Roy Insley
14. MOTHER'S MAIDEN NAME: Mollie Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Roy D. Insley — ADDRESS: 630 Portland St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
(A) diarhea — DUE TO
(B) Cardiac failure — DUE TO
(C) dehydration + acidosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [4] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-21, 1949 *to* 10-22, 1949, *that I last saw the deceased alive on* 10-22, 1949, *and that death occurred at* 1030 *m., from the causes and on the date stated above.*

23A. SIGNATURE: E J Brodbeck M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 10-22

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/24/49
24C. NAME OF CEMETERY OR CREMATORY: Balto.
24D. LOCATION (City, town, or county) (State): Balto, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 150

1190

If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:78

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

Registered No. G79:78

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARIE A. REINEK

2. DATE OF DEATH 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balto Gen'l Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1450 Hull St. 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Aug 14th 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Germany | |

13. FATHER'S NAME Paul Hofer

14. MOTHER'S MAIDEN NAME Alma Ludiorff

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Wm H. Reinek 4110 Sherbrook Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage, massive, Left hemisphere

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-18-49 *to* 10-22-49, *that I last saw the deceased alive on* 10-22-49, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D. Grayson M. D. | Sr B. C. H. | 10-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/25/49 | Cedar Hill | a.a.Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS
Wm Cook Inc 1217 St. Paul St.

VS 150

83a

G79:79 G79:79

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marie Jester 3 22 1

2. DATE OF DEATH: Oct. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-02
D. STREET ADDRESS (If rural, give location): 1113 E. Pratt St.

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | U | U | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| N K | N K | N K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | N O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| W N | | | W N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Alcoholism

DUE TO

(B) Chronic Alcoholism

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | [ ] / [X] / [ ] | Oct. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | OCT 14 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, MD | Commissioner of Health | |

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G79180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79180

1. NAME OF DECEASED (Type or Print): Louisa Washington

2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital
C. Length of stay in Baltimore: 40 yrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 16-B-3
D. STREET ADDRESS (If rural, give location): 802 N. Calvert St

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1877
9. AGE (In years last birthday): 72 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Essex Co. Va
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Isaac Russell
14. MOTHER'S MAIDEN NAME: Amanda Bagby
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Dalloth Baker ADDRESS: 802 N. Calvert St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C V Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. J. Verbrycke M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Int
24B. DATE: Oct 24-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): a. a. Co Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James A. Hayes ADDRESS: 608 N. Pitcher St

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be correct as age is especially important. Physicians: please write the causes of death clearly and legibly.

939

G79181

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79181

1. NAME OF DECEASED (Type or Print): MAX MAKOFF
2. DATE OF DEATH: October 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4613 Park Heights Avenue
c. Length of stay in Baltimore: 9 Mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4613 Park Heights Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | DIVORCED | 1873 | 76 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Isaac Makoff
14. MOTHER'S MAIDEN NAME: Fannie ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: David Markoff ADDRESS: 3204 Dorchester Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arterio-Sclerotic Cardio Vasc Renal | 10 years |
| DUE TO (B) | Hypertension & Cerebral Hemorrhage | 8 days |
| DUE TO (C) | Pulmonary Edema - Cardiac Exhaustion | 8 days |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct, 1946 *to* Oct. 21, 1949, *that I last saw the deceased alive on* Oct 21, 1949, *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Alex A Weinstock M. D. | 4603 K Hts Ave | 10-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-24-49 | Har Zion Cong. Cemety | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams M.D. | Sol. Levinson & Bros. | 1124-26 W North Ave. |

VS 150

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

79:82

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450 G79:82 Registered No.

1. NAME OF DECEASED (Type or Print): Brazier H. Griffin

2. DATE OF DEATH: Oct. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 935 W. Fayette St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Widowed | Mar 21, 1894 | 55 | 7 | 0 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Contractors | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Llewellyn Griffin | Josephine Butler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | U.S. Army | 217-05-6917 | Bertha Giles | Marriottsville Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L. Haussler M.D. | | Oct. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 25, 1949 | U.S. National Cemetery Bath. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1949 | Huntington Williams, M.D. | John M. Johnson | 1700 Druid Hill Ave. |

VS 151

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

G79:83 ✓ G79:83

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 173 Registered No.

1. NAME OF DECEASED (Type or Print): Ella Nora Wheat

2. DATE OF DEATH: Oct. 21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1609 W. Lombard St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04

D. STREET ADDRESS (If rural, give location): 1609 W. Lombard St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 29, 1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cavey

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Wm. W. Wheat, 1609 W. Lombard St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Oedema — Interval between onset and death: 1 day

DUE TO

(B) General Arteriosclerosis — 3 Mos

DUE TO

(C) Carcinoma of Uterus — 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Myocarditis

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 30, 1948, to Oct 21, 1949 *that I last saw the deceased alive on* Oct 20 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: James Katzenberg M. D.

23B. ADDRESS: 721 Medical Arts Bldg

23C. DATE SIGNED: 10/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 24/49

24C. NAME OF CEMETERY OR CREMATORY: St. Paul's Methodist Ch. Cemty.

24D. LOCATION (City, town, or county) (State): Granite, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry F. Luitzke

ADDRESS: 4101 Edmondson Ave.

VS 150

482

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:84 ✓ G79:84

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 490

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Taney

2. DATE OF DEATH: October 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): 428 East St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 2-7-1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Odd Jobs | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Toney | Winifred Toney |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Pneumococci

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-19, 1949, *to* 10-19, 1949, *that I last saw the deceased alive on* 10-19, 1949, *and that death occurred at* 4:40 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip D. Nagle M. D. | JOHNS HOPKINS HOSPITAL | Oct. 20, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 10/25 | Prospect Hill Cemetery | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | A Halsted | 918 Dru[illegible] |

VS 150

108

Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

79185

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

79185

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Agnes Shirley Schultheis

2. DATE OF DEATH: Oct. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3709 Wilkens Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-41
D. STREET ADDRESS (If rural, give location): 3709 Wilkens Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Feb. 10, 1927 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Maryland | U.S.A. |

13. FATHER'S NAME: Anthony W. Schultheis

14. MOTHER'S MAIDEN NAME: Florence Hirst

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | None | None | Anthony Schultheis | 3709 Wilkens Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. , 19 49 *to* Oct. 21, 19 49 *that I last saw the deceased alive on* Oct. 21, 19 49, *and that death occurred at* 10.00 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin J. Siegel M. D. | 15 Fremont Rd | Oct. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-24-49 | Loudon Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | George L. Schwab | 2101 Frederick ave. |

VS 150

136

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G79:86

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

754

G79:86

BIRTH NO. 49-07902 Registered No.

1. NAME OF DECEASED (Type or Print) DARLENE A. BAILEY

2. DATE OF DEATH 10-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
So. Balto. Gen. Hosp.

c. Length of stay in Baltimore — Yrs. / Mos. / Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 110 Edgeville Rd. (Brooklyn)

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S
8. DATE OF BIRTH: April 4, 1949
9. AGE (In years last birthday): 0 — If Under 1 Year: Months: 6, Days: 17; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John T. Bailey

14. MOTHER'S MAIDEN NAME: Lillie M. Lilley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mr & Mrs John T. Bailey ADDRESS: 110- Edgeville Rd.-25

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Interventricular septal defect.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-20-, 19 49 *to* 10-21-, 19 49, *that I last saw the deceased alive on* 10-21- 19 49 *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry D. Gruppian M. D.
23B. ADDRESS: S. B. G. H.
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 10/24/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 157E

If any items are unknown, please write "unknown". Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

679:87

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

99-8 Registered No. 679:87

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laura M. Miller (Laura Matilda Miller)

2. DATE OF DEATH 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 11-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1217 N Calvert Street

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed.
8. DATE OF BIRTH: Sept. 29, 1884
9. AGE (In years last birthday): 65 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical worker
10B. KIND OF BUSINESS OR INDUSTRY: Waverly Press

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Horstmeier

14. MOTHER'S MAIDEN NAME: Matilda King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO. 212-03-2082

17. INFORMANT: Miss Charlotte Miller ADDRESS: St. James Hotel #812

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Right Massive Pulmonary Infarction — (Interval between onset and death) 20 m.n.
DUE TO
(B) Diffuse Carcinomatosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 15 1949, to Oct. 22, 1949, *that I last saw the deceased alive on* Oct. 22 1949, *and that death occurred at* 11 03 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clifford D. Riddle Jr. M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 10/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 10/25/49
24C. NAME OF CEMETERY OR CREMATORY: Trinity cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. ADDRESS:

VS 150

BALTIMORE - 13, MARYLAND 55E

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

679:88

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 7 x 4

679:88

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lucy Clark

2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 223 W/Hill Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 223 W. Hill Street

c. Length of stay in Baltimore: 19Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 22-02
D. STREET ADDRESS (If rural, give location): 223 W. Hill Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | W | 9/12/1900 | 49 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | North Carolina | U.S.A. |

13. FATHER'S NAME: George Robinson

14. MOTHER'S MAIDEN NAME: Annie Brooks

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Reverdy Brooks | 223 W. Hill St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Cardiac Failure | 1 days |
| DUE TO | | |
| (B) | Unknown | |
| DUE TO | | |
| (C) | Chronic Arthritis | Unknown |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 14, 1949 *to* Oct 21, 1949, *that I last saw the deceased alive on* Oct 20, 1949 *and that death occurred at* 12-30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John W. Laine M.D. | 507 W. Hamburg St | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 10/25/49 | Mt Auburn Ct | Baltimore, City. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | D. L. Burns & Son | 108 W. Montgomery St |

VS 150

59B

Please write clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79:89

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 vr. 1

G79:89

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET E. SLATTERY

2. DATE OF DEATH: 10-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 423 N. LUZERNE Ave

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE 6-02
D. STREET ADDRESS (If rural, give location) 423 N. LUZERNE Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Single | Oct 4, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Maryland | |

13. FATHER'S NAME: Florence W. SLATTERY

14. MOTHER'S MAIDEN NAME: Anne E. Scanlon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Eugene B. SLATTERY | 300 Buckeye Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V. disease — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) Arteriosclerosis generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Malnutrition — 3 mos.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/16/49, 19__, *to* 10/21, 1949 *that I last saw the deceased alive on* 10/21, 1949 *and that death occurred at* 4P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benj. B. Moore M. D. | 448 N. Eutaw Ave. | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-25-49 | New Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Hunter for Williams, M.D. | John G. Morgan | 3000 E. Balto St. |

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians

G79190

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79190

1. NAME OF DECEASED (Type or Print): EDWARD ROSENSTEEL
2. DATE OF DEATH: 22 Oct 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: Yrs. life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE - 18 MD.
D. STREET ADDRESS (If rural, give location): 641 DUMBARTON AVE 9-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 3-18-1879 | 70 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE PLUMBER
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph E. Rosensteel
14. MOTHER'S MAIDEN NAME: Margaret Seim
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Gertrude R. Rosensteel ADDRESS 641 N. Ambaro

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MASSIVE GASTRO-INTESTINAL HEMORRAGE — INTERVAL BETWEEN ONSET AND DEATH: LESS THAN 18 HOURS.
DUE TO
(B) POSSIBLE CARCINOMA OF THE STOMACH
DUE TO
(C) H

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
HYPERTENSIVE CARDIO-VASCULAR DISEASE

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 21 Oct, 1949 to 22 Oct, 1949 that I last saw the deceased alive on 22 Oct, 1949, and that death occurred at 1 45 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Robert C. Hagan M. D.
23B. ADDRESS: UNIVERSITY HOSPITAL
23C. DATE SIGNED: 22 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-25-49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran ADDRESS: 3000 E Balto St.

VS 150

462

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure that the cause of death is stated correctly and completely. Accuracy and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:91

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 331 Registered No. G79:91

1. NAME OF DECEASED (Type or Print): Emma F. Walters

2. DATE OF DEATH: October 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 26-06
D. STREET ADDRESS (If rural, give location): 1221 Urban Way.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | October 18, 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Schmitman

14. MOTHER'S MAIDEN NAME: Minnie Klinganhafer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage. | 11 days |
| DUE TO (B) | Hypertension | 15 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 20, 1949, *to* Oct. 21, 1949, *that I last saw the deceased alive on* Oct. 21, 1949, *and that death occurred at* 4:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: William A. Ranson M.D.

23B. ADDRESS: Union Memorial Hospital

23C. DATE SIGNED: Oct. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/25/49

24C. NAME OF CEMETERY OR CREMATORY: Schmaltz

24D. LOCATION (City, town, or county) (State): O'Donnell Lot

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Coleman & Hoffman ADDRESS: 1639 Broadway

VS 150

830a

PLEASE WRITE PLAINLY WITH INK. Use no abbreviations. Omit no items. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:92

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 41 6 Registered No. G79:92

1. NAME OF DECEASED (Type or Print): Stencel, Irvin R.

2. DATE OF DEATH: 10-21-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Franklin Sq. Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: 47 Yrs. 10 Mos. 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-11
D. STREET ADDRESS (If rural, give location): 401 N. Fulton Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3-11-1902
9. AGE (In years last birthday): 47 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Stencel
14. MOTHER'S MAIDEN NAME: Blanche Schreiver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 214-01-9209
17. INFORMANT: Naomi Stencel — ADDRESS: 401 N. Fulton Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
(B) Rheumatic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10-, 1949 *to* 10-21-, 1949, *that I last saw the deceased alive on* 10-21-, 1949, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS:
23C. DATE SIGNED: 10-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-25-1949
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, Town, or County): Baltimore (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: [signature] for Nathaniel, M.D.
25. FUNERAL DIRECTOR: J. Howard Young — ADDRESS: 3207 W. North Ave.

VS 150
4205V
93c

G79:93

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 17°

Registered No. G79:93

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillie M Jackson

2. DATE OF DEATH: Oct 22-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2583 Edmondson Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 20-02
D. STREET ADDRESS (If rural, give location): 2583 Edmondson Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | Single | July 2-1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Host | — | Talbot Co Md. | U.S.A. |

13. FATHER'S NAME: Nicholas V Jackson

14. MOTHER'S MAIDEN NAME: Josiah Jane Cummings

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mrs Maywood P Burt | 2583 Edmondson |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Adenocarcinoma left Breast | 3 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Metastasis to Left + Right Clavicle + Chest | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct 9, 1949 | Adenocarcinoma | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 21 1949 *to* Oct 22, 1949 *that I last saw the deceased alive on* Oct 21, 1949, *and that death occurred at* 11:45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C Bradley Dansbarby M. D. | 3033 W North Ave | Oct 22 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 25-1949 | Olivet | Ft Mitchell Ky |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT | Livingston Williams, M.D. | Peter J Lore | 2224 Eutaw Pl |

VS 150

50

PLEASE WRITE PLAINLY WITH INDELIBLE INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

679:94 BALTIMORE CITY HEALTH DEPARTMENT 679:94

BIRTH NO.

# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY ZASLAVSKY

2. DATE OF DEATH 10-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levindale
C. Length of stay in Baltimore 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY 27-16
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4514 Pimlico Road

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH
9. AGE (In years last birthday) 69 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10B. KIND OF BUSINESS OR INDUSTRY Overall Mfg
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles
14. MOTHER'S MAIDEN NAME Hannah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Minnie Zaslavsky ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic cardiovascular disease DUE TO
(B) Arteriosderosis DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: years

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6-24-49 *to* 10-23 19 49, *that I last saw the deceased alive on* 10-23 19 49, *and that death occurred at* 8 20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry Nagel M. D.
23B. ADDRESS Levindale Home
23C. DATE SIGNED 10-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-24-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

93D

G79:95

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

420 Registered No. G79:95

1. NAME OF DECEASED (Type or Print) Mary Ruth Davis

2. DATE OF DEATH 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Women's Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for Women of Maryland

c. Length of stay in Baltimore 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY — 21-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 30, Maryland.
D. STREET ADDRESS (If rural, give location) 1132 West Cross Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 10-30-92 | 56 | 11 / 22 | — / — |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work

10B. KIND OF BUSINESS OR INDUSTRY at Home

11. BIRTHPLACE (State or foreign country) Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Richard Alexander Griffith

14. MOTHER'S MAIDEN NAME Theresa Magdelina Hinkhien

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT Sister ADDRESS 1132 W. Cross St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral-Vascular Accident — (Interval between onset and death) 96 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Dis. — 10 yrs.

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct. 21 1949 *to* Oct. 22, 1949, *that I last saw the deceased alive on* Oct. 22, 1949 *and that death occurred at* 9:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE John R Smith, Jr. M. D.

23B. ADDRESS Women's Hospital - Balto 17, Md

23C. DATE SIGNED 10/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10/26/49

24C. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.

24D. LOCATION (City, town, or county) (State) 2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J. Bowan & Son

ADDRESS 937 Hollins St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK and use only capital letters. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G79:96

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79:96

1. NAME OF DECEASED (Type or Print) Susie Russell

2. DATE OF DEATH Oct. 19-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 419 N. Dallas St

c. Length of stay in Baltimore Yrs. 6-05 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

D. STREET ADDRESS (If rural, give location) 419 N. Dallas St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | W | July 9 1892 | 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Eugene Hill

14. MOTHER'S MAIDEN NAME Mary Glotton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

If yes, give war or dates of service —

16. SOCIAL SECURITY NO. —

17. INFORMANT Rita Brown — ADDRESS 419 N. Dallas St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senile arteriosclerosis, DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 21, 1949, to 19 Oct, 19 49, *that I last saw the deceased alive on* 19 Oct, 19 49, *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE C. C. Burrell M. D.

23B. ADDRESS 171 Aisquith

23C. DATE SIGNED 10-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct. 24th 1949

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) A. A. Co Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949

REGISTRAR'S SIGNATURE Eunice for Williams, M.D.

25. FUNERAL DIRECTOR Byron Manier Knight — ADDRESS 721 Aisquith St

VS 150

PLEASE WRITE PLAINLY WITH UNFADING INK. Answer all questions fully. Where none, so state. Where unknown, or if the question is not applicable, write "unknown" or "N. A." To insure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

131a

G79:97

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79:97 Registered No. 3698

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Viola Gertrude Ayers

2. DATE OF DEATH 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 936 N. Stricker St.
C. Length of stay in Baltimore 49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY 16-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore city
D. STREET ADDRESS (If rural, give location) 936 N. Stricker St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | col. | married | 11-21-1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | own home | Sykesville md. | U.S.A. |

13. FATHER'S NAME Jerry Dorsey
14. MOTHER'S MAIDEN NAME Addella Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Henry Urban Ayers ADDRESS 936 Stricker St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocarditis | 14 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Chr. Nephritis | unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-19, 1939 *to* 10-22, 1949, *that I last saw the deceased alive on* 10-22, 1949, *and that death occurred at* 5:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jno. A. Saunders M. D. | 1029 N. Stricker St | 10-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-25-49 | Mt. Auburn | Balto. City |

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Samuel W. Sullivan Jr 1011 N. Arlington Ave

VS 150

PLEASE WRITE PLAINLY IN INK AND GIVE ENTIRE ENTRY. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679:98

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1300

679:98

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Robert Jones

2. DATE OF DEATH OCT 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore 11 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-02
D. STREET ADDRESS (If rural, give location) 1108 Goodyear St

5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3-6-03
9. AGE (In years last birthday) 46
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Meat

11. BIRTHPLACE (State or foreign country) N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Jones
14. MOTHER'S MAIDEN NAME Missouri Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Heart failure
DUE TO
(B) Acute bacterial endocarditis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) 2 wks.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-15, 1949 *to* 10-22, 1949, *that I last saw the deceased alive on* 10-22, 1949, *and that death occurred at* 1030 *m., from the causes and on the date stated above.*

23A. SIGNATURE Phillips D Nagley M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED Oct 23, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-30-49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Easton - Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
REGISTRAR'S SIGNATURE Registrar for Williams, M.D.
25. FUNERAL DIRECTOR Samuel W. Sullivan Jr ADDRESS 91a 1011 N. Arlington Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Do not leave blanks. Be sure that correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:99

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 56 1 G79:99 Registered No.

1. NAME OF DECEASED (Type or Print): Irvin Pollack

2. DATE OF DEATH: 10-20-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp

C. Length of stay in Baltimore: Yrs. 16-02 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1401 Winchester St.

5. SEX: M
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 23, 1894
9. AGE (In years last birthday): 55 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labourer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Amelia County Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jackson Pollack
14. MOTHER'S MAIDEN NAME: Fanny Fiches.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Martha Pollack ADDRESS: 1401 Winchester St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pos. Carcinoma of liver. — INTERVAL BETWEEN ONSET AND DEATH: Undet.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-19-49 to 10-20, 1949, that I last saw the deceased alive on 10-20, 1949, and that death occurred at 1:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Irvin W. Cooper M.D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED: Oct. 20 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 24 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Kate R. Williams ADDRESS: 3234 Edmondson Ave

VS 150

46F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Insert correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 10-27-49

BIRTH NO. 679200

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 679200

1. NAME OF DECEASED (Type or Print): Jesse Rayburn Phillips

2. DATE OF DEATH: 10-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
c. Length of stay in Baltimore: 73 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto city
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 27-15
D. STREET ADDRESS (If rural, give location): 1427 Forge Ave. #9

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 10-29-1876
9. AGE (In years last birthday): 73 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Phillips
14. MOTHER'S MAIDEN NAME: Mary C. Tillings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 242-14-2206
17. INFORMANT: Mrs. Florence Turnbough. ADDRESS: Same.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis, localized — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Perforation of gall bladder
DUE TO
(C) Cholecystitis, acute

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10-19-49
19B. MAJOR FINDINGS OF OPERATION: Empyema Gall Bladder Peritonitis.
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19, 1949 *to* 10-23, 1949 *that I last saw the deceased alive on* 10-23, 1949, *and that death occurred at* 8:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John S. Green, M. D.
23B. ADDRESS: Union Memorial Hosp
23C. DATE SIGNED: 10-23 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/26/49
24C. NAME OF CEMETERY OR CREMATORY: St Mary's
24D. LOCATION (City, town, or county) (State): Hampden.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank E. Thomann & Son ADDRESS: 2015-17 Chestnut Ave.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct as age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

127a

G79201 — BALTIMORE CITY HEALTH DEPARTMENT — G79201

# CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Homer Martin Parker
2. DATE OF DEATH: 10-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen'l Hosp.
C. Length of stay in Baltimore: 17 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 710 Register Avenue #12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | 12-6-1842 | 5 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Lawrence Parker
14. MOTHER'S MAIDEN NAME: Bertha Wagner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 212-09-3807
17. INFORMANT: Mrs. Homer M Parker ADDRESS: 710 Regester Ave #12

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute coronary occlusion (anginal attacks) — INTERVAL BETWEEN ONSET AND DEATH: 5 hours (several) mos.
DUE TO
(B) Arteriosclerotic heart disease — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23 1949 *to* 10-23 1949 *that I last saw the deceased alive on* 10-23 1949 *and that death occurred at* 5:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Candler M.D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 10-23-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 25 1949 | Druid Ridge | Baltimore Co. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Henry W. Jenkins Sons Co. ADDRESS: 4905 York Rd Balto 12 Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679-02 ✓ X 679-02

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ELBERT PARKER MOORE

2. DATE OF DEATH: 10. 21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT HOSPITAL

c. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 319 Conway Ave

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5.1.87
9. AGE (In years last birthday): 62 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elevator operator
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Easton, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Walter J. Moore
14. MOTHER'S MAIDEN NAME: Anna M. Dorsey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Camilla Moore ADDRESS: 319 Conway Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) previous coronary occlusion — 8 mos.
DUE TO

(C) arteriosclerotic heart disease — 5 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 28 1949 *to* Oct 21, 1949 *that I last saw the deceased alive on* Oct 21, 1949, *and that death occurred at* 5:55 *m., from the causes and on the date stated above.*

23A. SIGNATURE: James D. Carr M. D.
23B. ADDRESS: 1427 Madison Ave Balto-17
23C. DATE SIGNED: 10-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-24-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: William A. Jackson ADDRESS: 916 Penna Ave.

VS 150

PLEASE WRITE PLAINLY. WITH UNFADED INK. Entries must be complete and correct as far as possible. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25. Please write the cause of death clearly and legibly. Date of death is especially important. Physician: please write the cause of death clearly and legibly.

937

G79-03

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

DEC 1 1949

G79-03

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Mettie P. Gries

2. DATE OF DEATH: Oct. 21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2004 Ramsay St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-03
D. STREET ADDRESS (If rural, give location): 2004 Ramsay St.

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 4, 1898
9. AGE (In years last birthday): 51 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): N. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Congleton
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph Gries — ADDRESS: 2004 Ramsay St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Occlusion | sudden |
| DUE TO | | |
| (B) | Hypertensive Cardio Vascular Renal | 2-3 yr |
| DUE TO | | |
| (C) | Coronary Sclerosis | 2-3 yr |

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Sept 1949, 19__, to Oct 21st, 1949, *that I last saw the deceased alive on* 2:30 P.M. Oct 21 1949, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. E. Davis MD, M. D.
23B. ADDRESS: 642 Wash Blvd
23C. DATE SIGNED: 10-24-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 25/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Harry H. Lustfe, 4101 Edmondson Ave.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Please see that correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79204

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

42 G79204

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOHN ROSE

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2351 Annapolis Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2351 Annapolis Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 14, 1868 | 80 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paymaster(r't'd)
10B. KIND OF BUSINESS OR INDUSTRY: Gas Co.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: ? Rose
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Rose May Rose ADDRESS: 2351 Annapolis Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V.D. — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

(B) Hypertension C.V.D. — 2 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* Oct 22, 1949, *that I last saw the deceased alive on* Oct 22, 1949, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 7201 Arunpd Rd
23C. DATE SIGNED: 10/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/25/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79.05

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4115 Registered No. G79.05

1. NAME OF DECEASED (Type or Print): EVA LOUISE NEELY

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 604 Craycombe Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-07
D. STREET ADDRESS (If rural, give location): 604 Craycombe Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Nov. 4, 1893 | 55 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Virginia | |

13. FATHER'S NAME: George E. Marx

14. MOTHER'S MAIDEN NAME: Lilla R. Burley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. James Neely, Jr. | 604 Craycombe Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Heart Disease and Hypertensive Cardio-Vascular Disease

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* ____, 1946 *to* October 22, 1949 *that I last saw the deceased alive on* October 21, 1949, *and that death occurred at* 10:00 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maryland Edward Day M. D. | 4-E-32nd St - | October 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/25/49 | Mt. Olivet Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93c

G79-06

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 81.0

G79-06

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — L.W. Lee Sakers.

2. DATE OF DEATH — October 23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — University of MD. Hospital

C. Length of stay in Baltimore — Yrs. 87 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — MARYLAND.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — BALTIMORE MD 12-08
D. STREET ADDRESS (If rural, give location) — 1334 DELWOOD AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | White. | | May 12-1867 | 82 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — CARPENTER

10B. KIND OF BUSINESS OR INDUSTRY — Self employed

11. BIRTHPLACE (State or foreign country) — MARYLAND.

12. CITIZEN OF WHAT COUNTRY? — USA

13. FATHER'S NAME — John Sakers.

14. MOTHER'S MAIDEN NAME — FANNIE Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — ?
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT — Ella Buffington — ADDRESS — Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

B) Laennec's Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 2+ years

DUE TO

A) Esophageal Varices & hemorrhage

DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 10/17/49

19B. MAJOR FINDINGS OF OPERATION — Laennec's Cirrhosis

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/16, 1949, to 10/23, 1949, *that I last saw the deceased alive on* 10/23, 1949, *and that death occurred at* 5:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE — Mark E Hoey Jr. M.D.

23B. ADDRESS — U of Md. Hosp

23C. DATE SIGNED — 10/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) — 24B. DATE — Oct. 26-1949

24C. NAME OF CEMETERY OR CREMATORY — Ivy Hill

24D. LOCATION (City, town, or county) (State) — Laurel, Maryland

DATE RECEIVED BY LOCAL REGISTRAR — OCT 26 1949

REGISTRAR'S SIGNATURE — Huntington Williams, M.D.

25. FUNERAL DIRECTOR — Burgee Funeral Home — ADDRESS — 6531 Falls Road

VS 150

124a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Accuracy supplying correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679.07

CERTIFICATE CORRECTED 10-25-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679.07

BIRTH NO. 080.0 Registered No.

1. NAME OF DECEASED (Type or Print) ROBERT HOMER ENGLE

2. DATE OF DEATH OCTOBER 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SYDENHAM HOSPITAL

c. Length of stay in Baltimore 25 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 21-09
D. STREET ADDRESS (If rural, give location) 1575 WINSTON ROAD

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | MARCH 17, 1920 | 29 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) SCRANTON, PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BENJAMIN HOMER ENGLE

14. MOTHER'S MAIDEN NAME RUTH BENNETT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES

(If yes, give war or dates of service) WORLD WAR II

16. SOCIAL SECURITY NO

17. INFORMANT Ruth ADDRESS ROBIN N. ENGLE (WIFE) 1575 WINSTON ROAD Winston

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIAC FAILURE

DUE TO SPINAL AND BULBAR PARALYTIC ACUTE ANTERIOR POLIOMYELITIS

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 14 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* OCTOBER 11, 1949 *to* OCTOBER 23, 1949, *that I last saw the deceased alive on* Oct 23, 1949, *and that death occurred at* 12⁰³ P m., *from the causes and on the date stated above.*

23A. SIGNATURE Latimer G. Young M. D.

23B. ADDRESS SYDENHAM HOSPITAL

23C. DATE SIGNED OCT 23, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10-24-1949

24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park

24D. LOCATION (City, town, or county) Baltimore Co. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR 10-24-49

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Durgee Funeral Home ADDRESS 3631 Falls Road

VS 150

26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as far as possible, and carefully supplied. Physicians: please write the cause of death clearly and legibly.

D.O.A. G79-08 B.L. 7-93509 ✓
Medical Examiners case released to Hospital

BIRTH NO. 3 5 3 ✓ G79-08

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Robert Vanke

2. DATE OF DEATH October 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-04
D. STREET ADDRESS (If rural, give location) 2227 E. Chase St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | January 1st 1944 | 5 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Solen Vanke
14. MOTHER'S MAIDEN NAME Martha Brown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS John Vanke 2227 E. Chase St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Status Epilepticus
DUE TO
(B) Mental retardation
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R S Fraber M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Lowell Thrush M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 10-21-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | October 24th 1949 | Sacred Heart of Mary | German Hill Road |

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
25. FUNERAL DIRECTOR ADDRESS Leo Gude 1703 N. Patterson Park

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Accuracy in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Medical Examiner to approve certificates 85

G79-09

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 3 ✓ Registered No. G79-09

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Raymond Joseph Bukowski

2. DATE OF DEATH Oct. 22, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Md.
B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location) St. Joseph's Hospital
c. Length of stay in Baltimore 59 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5966 Glen Falls Ave. 27-24

5. SEX M.
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Dec 26. 1888
9. AGE (In years last birthday) 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed
10B. KIND OF BUSINESS OR INDUSTRY Longshoreman
11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Bukowski
14. MOTHER'S MAIDEN NAME Mary Bartecki
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-03-4888
17. INFORMANT Jenny Bukowski ADDRESS 5966 Glen Falls ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Generalized arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 21, 1949 *to* Oct. 22, 1949, *that I last saw the deceased alive on* Oct. 22, 1949, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE S. K. Kaan M. D.
23B. ADDRESS 1400 N. Caroline St.
23C. DATE SIGNED Oct. 22, 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 26-1949
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary
24D. LOCATION (City, town, or county) (State) Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. L. Flatkowski ADDRESS 2007 Eastern ave

VS 150

83B

BIRTH NO. G79210

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79210

1. NAME OF DECEASED (Type or Print): WILLIAM KARWACKI

2. DATE OF DEATH: October 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 337 S. Ann Street

c. Length of stay in Baltimore: 55 Yrs. Mos. Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 337 S. Ann Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | December 29, 1868 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shoemaker- Ret. | Self | Poland | |

13. FATHER'S NAME: ---------- Karwacki

14. MOTHER'S MAIDEN NAME: Anastasia ----------

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | --- | Mrs. Wladyslawa Karwacki, 337 S. Ann Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — Generalized — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 19, 1949 *to* Oct 21, 1949 *that I last saw the deceased alive on* Oct 21 1949 *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis F. Kilimes M. D. | 2623 E. Monument St | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/25/49 | Holy Rosary | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 24 1949 | Thurlington Williams, M.D. | M.F. Sadowski & Sons, 1808 Eastern Aveme |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

94a

G79211

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 171

G79211

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) ANNE MASON

2. DATE OF DEATH October 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3206 Tate Street
C. Length of stay in Baltimore 21 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-06
D. STREET ADDRESS (If rural, give location) 3206 Tate Street

5. SEX female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 12/?/96
9. AGE (In years last birthday) 52 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10B. KIND OF BUSINESS OR INDUSTRY –
11. BIRTHPLACE (State or foreign country) Rockhill S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph Stinson
14. MOTHER'S MAIDEN NAME Francis ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) – (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Jamie Mae Lon ADDRESS 3206 Tate St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the cervix
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Carl A. Rose M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED Oct. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct. 25/1949
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Im.
24D. LOCATION (City, town, or county) (State) A.A.Co. Md

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
REGISTRAR'S SIGNATURE Hunting for Williams, M.D.
25. FUNERAL DIRECTOR Robert E. Williams ADDRESS 1515 Mcelderry St

VS 48a

BIRTH NO. G79212

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79212

1. NAME OF DECEASED (Type or Print): DOROTHY WASHINGTON

2. DATE OF DEATH: October 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 5-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1204 McElderry Street

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 12, 1931
9. AGE (In years last birthday): 18 (If under 1 Year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Columbia S.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ernest Washington
14. MOTHER'S MAIDEN NAME: Annie Ruth Washington
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Annie Ruth Washington ADDRESS: 1204 McE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Advanced pulmonary tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Oct. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 24 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem
24D. LOCATION (City, town, or county) (State): A.A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Robert A. Elliott, Daughter ADDRESS: 130 1129 N. Carlton St.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79213 G79213

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ALMA NETTLES — N-606.

2. DATE OF DEATH October 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-16
D. STREET ADDRESS (If rural, give location) 3220 Weedon Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | married | | 42 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) N. C
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hamp Wilson
14. MOTHER'S MAIDEN NAME Margaret Wilson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Theodore Jefferson ADDRESS 1310 Hunter St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Precipitation
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) freight yard
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3100 block of Remley St. B & O Fairfield Freight Yard,
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) October 21, 1949 9.30pm.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Run over by freight car 25/6

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Oct. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE Oct 25/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State) Charlotte N. C.

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Mrs Robert G. Elliott & Daughter 169 1129 N. Carolina Ave

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79214 ✓ 80.0 G79214

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Spencer, William Elmer, Jr.

2. DATE OF DEATH: October 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital, Baltimore, Md.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland, B. COUNTY: City of Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): City of Baltimore
D. STREET ADDRESS (If rural, give location): 1621 Homestead Street 9-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | w | mar. | Aug. 23, 1928 | 21 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steelworker | Bethlehem Steel | Fall River, Mass. | U.S.A. |

13. FATHER'S NAME: William Elmer Spencer, Sr.

14. MOTHER'S MAIDEN NAME: Louise Dickerson ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW2-10/9/45 to 3/4/48 | 262-38-1166 | U.S.Marine Hospital, | Baltimore, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Anterior Poliomyelitis | 1 week |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 20, 19 49 *to* Oct 22, 19 49, *that I last saw the deceased alive on* Oct 22, 19 49 *and that death occurred at* 2:25 a.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Jm. Stewart 3A. 3rd Cy.
John L. Wilson, Clinical Director M. D. | 23B. ADDRESS: U.S. Marine Hospital, Balto., Md. | 23C. DATE SIGNED: Oct. 22, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 10/26/49 | Baltimore National | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: Oct 24 1949 | REGISTRAR'S SIGNATURE: Thurlington for Williams M.D. | 25. FUNERAL DIRECTOR: Ulrich Funeral Home | ADDRESS: 597 Fulton Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G79215

JL - 132509

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17° Registered No. G79215

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mary Wilson

2. DATE OF DEATH: 10-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 14 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-02
D. STREET ADDRESS (If rural, give location): 819 Central Ave.

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Div.
8. DATE OF BIRTH: June 15, 1901
9. AGE (In years last birthday): 48 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ala.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jim Read
14. MOTHER'S MAIDEN NAME: Carrie Phelps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis

DUE TO

(B) Metastic Carcinoma of left Breast

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: May 28 1947
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Left Breast
20. AUTOPSY? YES [Yes] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10, 1949 *to* Oct. 23, 1949 *that I last saw the deceased alive on* Oct. 23, 1949, *and that death occurred at* 8.30 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Logan M. D.
23B. ADDRESS: 4940 Eastern Ave
23C. DATE SIGNED: 10-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 27/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): B.A. County Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Herbert A. Elliott Dyl ADDRESS: 1129 N. Carlton St

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G79216

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

401.1

G79216

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Richard Biniasz

2. DATE OF DEATH Oct 23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2014 Jefferson St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 2014 Jefferson B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-05

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2014 Jefferson St

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH July 8, 1927

9. AGE (In years last birthday) 22 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Drug Clerk

10B. KIND OF BUSINESS OR INDUSTRY Bloom Drug Store

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Casimer Biniasz

14. MOTHER'S MAIDEN NAME Catherine Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO 169-26-9012

17. INFORMANT Mr. Casimer Biniasz ADDRESS 2014 Jefferson St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Rheumatic Fever

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Mitral Insufficiency (Decompensating)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 15, 1949 *to* Oct. 23, 1949 *that I last saw the deceased alive on* Oct. 23, 1949, *and that death occurred at* 3:37 A m., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.

23B. ADDRESS 2329 Eastern Av

23C. DATE SIGNED 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Oct 26/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR OCT 24 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Phillips Herwig Sons

ADDRESS 2024 Eastern Av

VS 150

92B

G79217 G79217

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

154 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FLORENCE JANE McCORMICK

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2704 Edmondson Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06
D. STREET ADDRESS (If rural, give location): 2704 Edmondson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Married | July 6, 1888 | 61 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at Home | Baltimore, Md. | |

13. FATHER'S NAME: Charles W. Green

14. MOTHER'S MAIDEN NAME: Rebecca R. Henry

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Eva Z. Howland | 2704 Edmondson Av. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 months.

DUE TO

(B) Carcinoma of rectum — 1 year

DUE TO

(C) Chronic hypocardial disease arteriosclerosis with arteriosclerotic type heart dis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 1949 | Inoperable rectal carcinoma | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* August 24 1949 *to* Oct 22, 1949 *that I last saw the deceased alive on* Oct 22, 1949, *and that death occurred at* 7.30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. Nichel M.D. M. D. | 1015 Poplar Grove St | Oct 24 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

46D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79218

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 G79218

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): George Dabrasky

2. DATE OF DEATH: 10/22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3133 Belmont Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 29, 1881
9. AGE (In years last birthday): 68 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fed. Meat Inspec.
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Dabrasky
14. MOTHER'S MAIDEN NAME: Augusta Schmetz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs. Eva May Dabrasky ADDRESS: 3133 Belmont Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL VASCULAR ACCIDENT (RIGHT) E — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) LEFT SIDED HEMAPLEGIA

DUE TO (C) HYPERTENSIVE ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/21, 1949 *to* 10/22, 1949 *that I last saw the deceased alive on* 10/22, 1949 *and that death occurred at* 7:30 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Ahern M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 10/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/25/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 24 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

93D

G79219

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79219

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM HENRY ENSOR

2. DATE OF DEATH: Oct. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3910 Groveland Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 3910 Groveland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Oct. 21, 1872 | 77 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sales Manager(rtd) | George Blome & Sons Co. | Balto., Md. | |

13. FATHER'S NAME: Thadeus Ensor

14. MOTHER'S MAIDEN NAME: Maria Griffith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mr. LeRoy Ensor 622 Worchester Rd. | Towson |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Angina Pectoris | about 1 hrs |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| — | | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 19th, 1949 *to* Oct 23rd, 1949, *that I last saw the deceased alive on* Oct 23rd, 1949 *and that death occurred at* 5 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|---|
| [signature] | | 3033 W Kert Rd | Oct 24 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

94 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79220 BALTIMORE CITY HEALTH DEPARTMENT G79220

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): KATHARINE L. M. BURNS
2. DATE OF DEATH: 10/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 12-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3109 N. Calvert St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Oct. 15, 1866 | 83 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Brookville, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William S. Milstead | Mary Jane Macartney |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Mr. William P. Burns - 3109 N. Calvert St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Cardiovascular Disease | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| John R Davis M.D. | | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/49 | Ivy Hill Cem. | Laurel, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 24 1949 | [illegible] | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

G79221 ✓ X No. 1 G79221

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Carroll Ezra Stem
2. DATE OF DEATH: 24 Oct. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Airy.
D. STREET ADDRESS (If rural, give location): Main Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7-23-1887
9. AGE (In years last birthday): 62 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Joseph T. Stem
14. MOTHER'S MAIDEN NAME: Charolette Wilt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): W. W. I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Effie B. Stem — ADDRESS: Mt. Airy Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammerer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 24 Oct. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-27-1949
24C. NAME OF CEMETERY OR CREMATORY: Taylorsville
24D. LOCATION (City, town, or county) (State): Carroll Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. M. Waltz — ADDRESS: Winfield. Md.
C. M. Waltz 9 & 2 Winfield, Md.

VS 151

G79222

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 3 31

Registered No. G79222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Hazel May Perkins

2. DATE OF DEATH: 10-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore Life 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07
D. STREET ADDRESS (If rural, give location) 217 N. 23 St

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 24, 1911
9. AGE (In years last birthday) 38
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Clerk
10B. KIND OF BUSINESS OR INDUSTRY Office
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME James E. Al Kinson
14. MOTHER'S MAIDEN NAME Elizabeth Warner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO 220-22-9982
17. INFORMANT Miss Ellis Stevens ADDRESS 1908 N. Chas. St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Intra cerebral hemorrhage | | Hours |
| DUE TO (B) Malignant Hypertension | | 2 years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/22, 1949, *to* 10/24, 1949, *that I last saw the deceased alive on* 10/24, 1949, *and that death occurred at* 4 1 m., *from the causes and on the date stated above.*

23A. SIGNATURE C. Richard Foard M. D.
23B. ADDRESS Mercy Hosp
23C. DATE SIGNED 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10/27/49
24C. NAME OF CEMETERY OR CREMATORY St. Peters
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1949
REGISTRAR'S SIGNATURE Lenington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St. Paul St.

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83a

679-23

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4 no. 1 — Registered No. 679-23

1. NAME OF DECEASED (Type or Print): Pansy Schmidt

2. DATE OF DEATH: 10/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1629 N. Calvert St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 12-05
D. STREET ADDRESS (If rural, give location): 1624 N. Calvert St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 4/25/1884
9. AGE (In years last birthday): 65 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles F. Eyler
14. MOTHER'S MAIDEN NAME: Emma D. Means
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Paul N. Link — ADDRESS: 143 E. 37th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis | |
| DUE TO | High Blood Pressure | |
| (B) | Hardening of Arteries | |
| DUE TO | | |
| (C) | Old Age | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-yr, 19[illegible] *to* Oct 23, 1949 *that I last saw the deceased alive on* Oct 20, 1949, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Hearn, M. D.
23B. ADDRESS: 7201 Garrison Blvd
23C. DATE SIGNED: 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/26/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Eastern Ave. Extended.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

61

679-24 679-24

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Bettie Patterson

2. DATE OF DEATH Oct - 23 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 22-01
D. STREET ADDRESS (If rural, give location) 617 S. Hanover st

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 617 S. Hanover st

c. Length of stay in Baltimore 15 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | col. | married | Mar - 15 - 1886 | 63 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Wife - | | Md. | |

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME Annie Holland

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Elizabeth Ponder | 635 S. Hanover |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Nephritis or Uremia

DUE TO
(B) Hypertension Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/15, 1949 *to* 10/23, 1949, *that I last saw the deceased alive on* 10/23, 1949, *and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Swarden M.D. | 1V - See ✓ | 10/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Oct. 26, 1949 | Fowlers Chapel | Best Gate, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | William Reese, II Annapolis, Md. 939 |

VS 150

G79 Hospital Disposal

G79-25

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

774

BIRTH NO. 49-22520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Baby Boy Christian "a"

2. DATE OF DEATH: Oct 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland (DO NOT ABBREVIATE) B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital Disposal

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-61

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1408 Mountmor Ct

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: 10-16-49

9. AGE (In years last birthday): If Under 1 Year: Months / Days; If Under 24 Hours: Hours 3 Min. 55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Christian

14. MOTHER'S MAIDEN NAME: Geneva Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16-, 1949, to 10-16-, 1949, *that I last saw the deceased alive on* 10-16-, 1949, *and that death occurred at* 7:10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis Ryan Hess M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 10-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Hospital Disposal

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS

VS 150

159

Hospital Disposal

BALTIMORE CITY HEALTH DEPARTMENT 114 G79-26

# CERTIFICATE OF DEATH

BIRTH NO. 49-22521 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Christian (B)

2. DATE OF DEATH: Oct 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fetal Prem

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 15-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1408 Mountmy St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 10-16-49
9. AGE (In years last birthday) | If under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 2 3/4

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Christian
14. MOTHER'S MAIDEN NAME: Minera Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16, 19 49, *to* 10-16, 19 49, *that I last saw the deceased alive on* 10-16, 19 49, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leone Rheuther M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hospital Disposal
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79227

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

154.3

G79227

BIRTH NO. 49-06175 Registered No.

1. NAME OF DECEASED (Type or Print): Francis Jr. Catz

2. DATE OF DEATH: Oct 22 49

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 706 South East Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | 3-20-49 | | 7 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | — | Md. | |

13. FATHER'S NAME: Frank Catz

14. MOTHER'S MAIDEN NAME: Margaret Bangert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Resides ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation

DUE TO

(B) Congenital Heart - acyanotic

DUE TO

(C) Intra-auricular septal defect

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 19, 1949 *to* Oct 22, 1949 *that I last saw the deceased alive on* Oct 22, 1949 *and that death occurred at* 5 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison C. Spencer M. D. | Johns Hopkins Hosp | 10-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-25-49 | Sacred Heart Cem. | Gorman Mill Rd Balto Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Charles S. Zeiler | 901 S. Eaton Hwy St. |

VS 150

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79228

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G79228

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): THOMAS H. WEITZEL

2. DATE OF DEATH: OCT. 22, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 3414 DILLON ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 26-09
D. STREET ADDRESS (If rural, give location) 3414 DILLON ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | DEC. 20, 1861 | 87 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED | AMER. CAN CO. | BALTIMORE, MD | U.S.A. |

13. FATHER'S NAME: HENRY WEITZEL

14. MOTHER'S MAIDEN NAME: UNKNOWN

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | ANNA THELEN | 3414 DILLON ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypertensive Cardio-Vascular Disease | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* OCT. 8, 1949 *to* OCT. 22, 1949 *that I last saw the deceased alive on* OCT. 21, 1949, *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Andrew Tumavosky M. D. | 2529 Eastern Ave. | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-25-49 | SACRED HEART CEM. | GERMAN HILL RD MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Charles S. Zeller | 901 S. Conkling St. |

VS 150

937

G79229

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. G79229

1. NAME OF DECEASED (Type or Print): JULIA C. BOCKLAGE
2. DATE OF DEATH: 10/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTO. GENERAL HOSP.
C. Length of stay in Baltimore: LIFE 74 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-11
D. STREET ADDRESS (If rural, give location): 1024 S. BOULDIN ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, (WIDOWED), DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 9-4-1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED | HOUSE-WORK | BALTIMORE, MD. | U.S.A. |

13. FATHER'S NAME: POETZEL
14. MOTHER'S MAIDEN NAME: ANTOINETTE FISCHER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA
DUE TO
(B) CHRONIC GLOMERULONEPHRITIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/20, 1949 *to* 10/23, 1949, *that I last saw the deceased alive on* 10/23, 1949, *and that death occurred at* 11:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William B. Cooper M. D.
23B. ADDRESS: South Balto General Hosp
23C. DATE SIGNED: 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 10-27-49
24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEM.
24D. LOCATION (City, town, or county) (State): GERMAN HILL RD BALTO. CO. MD

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles S. Zeiler
ADDRESS: 901 S. Lemmon St.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1210

AB-132531
679230

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

D 679230 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Frank Koushof

2. DATE OF DEATH: 10-11-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 217 President Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | ? | 77? | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Edema
DUE TO Arteriosclerotic Heart Disease
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-11- , 1949 *to* 10-11- , 1949, *that I last saw the deceased alive on* 10-11- , 1949, *and that death occurred at* 12.10 PM, *from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Rogan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10-12-1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State)
UNIVERSITY MEDICAL SCHOOL OCT 21 1949

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR
ADDRESS
Commissioner of Health

VS 150

To be approved by the Medical Examiner 939

G79231

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

581 1 G79231 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Elizabeth Harrod

2. DATE OF DEATH: Sept 29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1337 Stockton St
C. Length of stay in Baltimore: Yrs. 20 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-01
D. STREET ADDRESS (If rural, give location): 1337 Stockton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | Unknown | 65? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Md. | U. S. |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Thomas Walker | 1332 Stockton St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease — Interval between onset and death: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cirrhosis of Liver (Alcoholic) — Interval between onset and death: Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 7, 19 49, *to* Sept 29, 19 49, *that I last saw the deceased alive on* Sept 26, 19 49, *and that death occurred at* 5:45 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wilhelm Frey, M. D. | 1924 Penna Ave | Oct 13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL OCT 21 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Eutington for Williams, M.D. | Commissioner of Health | |

VS 150

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G79-232

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

451 Registered No. G79-232

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Gwynn

2. DATE OF DEATH: OCT 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 21 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-03
D. STREET ADDRESS (If rural, give location): 820 N. Vincent St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Married | 3-9-12 | 37 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Willie Rose | Sara Williams |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Ruptured sinus of valsalva | 1 mo |
| DUE TO | | |
| ANTECEDENT CAUSES | (B) Unknown | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-12- 1949 *to* 10-23, 1949 *that I last saw the deceased alive on* 10-23, 1949 *and that death occurred at* 5.06 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David E. Rogen M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-26-49 | Mt Auburn Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 25 1949 | Huntington Williams, MD | Mrs Frances A Hemsley 2780 W Biddle St |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

CARBON RESERVED FOR DUPLICATE

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79333

BIRTH NO. 379333

1. NAME OF DECEASED (Type or Print) OSCAR DAVIS

2. DATE OF DEATH October 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 527 W. Biddle Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Single | Oct. 29 1900 | 49 +0 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Florida
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Oscar Davis Sr.
14. MOTHER'S MAIDEN NAME Ruby Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Isiah Davis - ADDRESS 527 W. Biddle St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Advanced pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Oct. 24, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Mt. Auburn Cemetery | Maryland |

DATE RECEIVED BY LOCAL REGISTRAR OCT 25 1949
REGISTRAR'S SIGNATURE Contractor Williams, M.D.
25. FUNERAL DIRECTOR W. Halstead - ADDRESS 918 - 13B Druid Hill Ave

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G79234 — Vol 1 — G79234

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ignatius (Roibak) RYBAK
2. DATE OF DEATH: 10-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — University Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-04
D. STREET ADDRESS (If rural, give location): 2104 Aliceanna St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | July 18 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Labor | Poland | U.S.A. |

13. FATHER'S NAME: John Rybak
14. MOTHER'S MAIDEN NAME: Katarzyna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-07-7598
17. INFORMANT: KAZMIERA Katarzyna Rybak — ADDRESS 2104 Aliceanna St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | 2 hrs |
| DUE TO (B) | Coronary Thrombosis | 2 hrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23, 1949 *to* 10-23, 1949 *that I last saw the deceased alive on* 10-23, 1949 *and that death occurred at* 2:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: William J. Holloway M. D.
23B. ADDRESS: University Hospital - Baltimore
23C. DATE SIGNED: 10-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 27 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Baltimore County
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John M. Welby — 401 S. Chester Street

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G79235 — BALTIMORE CITY HEALTH DEPARTMENT — G79235

# CERTIFICATE OF DEATH

4/31 — Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. NAME OF DECEASED (Type or Print): Alice Miles

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400 Riggs Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

C. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1400 Riggs Ave — B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1400 Riggs ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | Col. | Widow | May. 1, 1886 | 63. | 5. | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | — | Baltimore Md | U.S. |

13. FATHER'S NAME: Alex. Butler

14. MOTHER'S MAIDEN NAME: Alice Butler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Alice Mae Medley | 1400 Riggs Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocarditis — Interval between onset and death: 7/2/49 to 10/20/49

DUE TO

(B) Diffused Nephritis — 10/20/49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Mother | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7/2/49 19__ *to* 10/20/1949 *that I last saw the deceased alive on* 10/20/1949 *and that death occurred at* 5.45 a.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. M. Lawrence M. D. | 1023 W. Lanvale st. | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 26/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Wm Brookes | 1463 N. Carey St |

VS 150

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

BIRTH NO. 379-38

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. 379-38

1. NAME OF DECEASED (Type or Print): Samuel Levy

2. DATE OF DEATH: 24 Oct. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-2
D. STREET ADDRESS (If rural, give location): 1600 No Appleton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | | 40 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Grocer | self | Baltimore Md | |

13. FATHER'S NAME: Maurice

14. MOTHER'S MAIDEN NAME: Jessie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Fannye Levy | 1600 N Appleton |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D | | 24 Oct. 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-25-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Jack Loewe Inc | 2100 Eutaw Pl |

VS 151

131a

(27) 679-357

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 679-357

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Albertus A. Peterman

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4515 Garrison Blvd. The Haven Nursing Home
C. Length of stay in Baltimore: 38 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
5210 Norwood Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 5210 Norwood Ave 28-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 26 1881 | 68 | 1 / 26 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Piano Tuner for | Baltimore City | Carroll Co. Md. | |

13. FATHER'S NAME: John Peterman

14. MOTHER'S MAIDEN NAME: Ceceilia Freidinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Bertha Irene Peterman ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

DUE TO

(B) Arteriosclerotic Cardio Vasc Disease

DUE TO

(C) Bronchitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct , 19 49 *to* Oct 25 19 49 *that I last saw the deceased alive on* Oct 24 19 49 *and that death occurred at* m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr Thos F Elliott M. D. | 4509 Liberty Heights | 10-24 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 25 49 | Loudon Park | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Ellsworth Armacost 5118 Gwyn Oak |

VS 150

Ellsworth Armacost 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(2) CERTIFICATE CORRECTED 10-27-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79238

BIRTH NO. G79238

1. NAME OF DECEASED (Type or Print): LOUIS OWENS N-F027

2. DATE OF DEATH: October 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | Feb. 21, 1872 | 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

DUE TO

(B) Intracranial hemorrhage

DUE TO

(C) Laceration of brain.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Hammonds Ferry Road & Nursery Lane, Anne Arundel County, Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 16, 1949 8:30 P m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 10-17-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Oct 26-1949 | Saints Peters | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Earl B. Wolverton Inc. 403-E-25th Street 1705

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G79239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 20-1 G79239

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MILLARD FILLMORE NEISSER

2. DATE OF DEATH: Sun. Oct 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1233 Patapsco St.

c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 1233 Patapsco St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 20-1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Utility Man | Movie Theater | Balto, Md. | U.S.A. |

13. FATHER'S NAME: James Neisser

14. MOTHER'S MAIDEN NAME: Emma Olson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 219-70-7097 | Mrs. Violet B. Neisser (wife) | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — 2 years

DUE TO

(C) Arteriosclerosis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Oct 19 49 to October 23 19 49 that I last saw the deceased alive on Oct 22 19 49 and that death occurred at 7 A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Nuller M.D. | 1218 Cleaden St | 10 Feb 1950 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. Oct. 26 49 | Parkwood Cem. | Balto. Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | A. Howard Evans | 1400 S. Charles St. Balto 30, Md. 94a |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Information is especially important. CHARGE FOR RECORDING FOR BINDING

G79240 ✓ 1 G79240

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Grace Virginia Kunker

2. DATE OF DEATH: Oct 24 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland 411 N.Pulaski St
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 411 N.Pulaski St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Mar 31 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Floor Housekeeper | Lord Balto Hotel | Baltimore Md | |

13. FATHER'S NAME: George French

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Gerald I.Lovenstein ADDRESS: 411 N.Pulaski St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Cardia- | ? |
| | DUE TO Vascular Disease | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March, 194[illegible] *to* Oct. 24, 1949 *that I last saw the deceased alive on* Oct. 24 1949 *and that death occurred at* 11:35 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| DCLuse Langdale M. D. | 4508 Edmondson Village | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 27 1949 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams, M.D. | Harry F. Ulmacat | 4204 Ridgewood Ave |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G79241 G79241

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 443

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. NAME OF DECEASED (Type or Print): Margaret Watts
2. DATE OF DEATH: 10-23-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: 45 (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 1020 W. Lafayette Ave
5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 30, 1899
9. AGE (In years last birthday): 50 50 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Ga.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: James Henderson
14. MOTHER'S MAIDEN NAME: Maggie Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Delaney Watts ADDRESS: 1020 Lafayette Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-vascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-2-, 1949, *to* 10-23, 19 49, *that I last saw the deceased alive on* 10-23, 19 49 *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: [illegible]
23C. DATE SIGNED: 10-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 26, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Lebanon
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. A. Nelson ADDRESS: 1303 Pennsylvania Ave.

VS 150

927

G79242 — 4201 — G79242

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Golaboske

2. DATE OF DEATH: Oct. 24-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3902 Southern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3902 Southern Ave. 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | MARRIED | Oct. 18-1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Osakiewski | Barbara Ostrowski |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr Walter Golaboske | 3902 Southern |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (B) Coronary Sclerosis

DUE TO (C) Hypertension arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Chronic diabetes mellitus + Prolapsed intervertebral disc, sciatica

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter A Anderson M. D. | 3001 Shannon Drive | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5305 Harford Rd. |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79243

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BARBARA WIGEY CHESNEY

2. DATE OF DEATH: Oct. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1829 E. North Ave
C. Length of stay in Baltimore: Yrs. Germany Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1829 E. North Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: April 30, 1877
9. AGE (In years last birthday): 72
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Martin Popp
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: 1829 E. North Avenue Mrs. Grace Beck Porter

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.

DUE TO

(B) Arteriosclerotic cardio-vascular disease — 9 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1941 *to* Oct. 22, 1949 *that I last saw the deceased alive on* Oct. 22 1949 *and that death occurred at* 6:30 P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. A. Krenzer M. D.
23B. ADDRESS: 1402 E. Fairmale St
23C. DATE SIGNED: 10-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 10/25/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS:

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BALTIMORE - 13, MARYLAND 931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79244 ✓ G79244

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Cecilia Zimmerman

2. DATE OF DEATH October 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ~~639 Oldham St.~~ 639 Oldham Street

C. Length of stay in Baltimore 38 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-07
D. STREET ADDRESS (If rural, give location) 639 Oldham Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | M- seperated | Jan. 1, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Finland | USA |

13. FATHER'S NAME: Edward Simonen

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: 639 Oldham Street ~~Ess~~ 24 Mr & Mrs Emil Tusa

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Oct. 24, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/27/49 | Oak lawn cemetery | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949

REGISTRAR'S SIGNATURE: Countersigned for Baltimore, Md.

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HEINBERG, IRENE — 1-7-1

2. DATE OF DEATH: 10/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL OF BALTO. INC.
C. Length of stay in Baltimore: 79 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 14-01
D. STREET ADDRESS (If rural, give location): MARLBORO APTS. HILTON AND GWYNN STS.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | SINGLE | June 19 1870 | 79 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): BALTO., MD.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leni Weinberger
14. MOTHER'S MAIDEN NAME: Eleanora Wheatfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: A Joseph ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF PAROTID GLAND
DUE TO & METASTASES.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/6/49 | CARCINOMA OF PAROTID | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* 10/24, 1949, *and that death occurred at* 12:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul C. Winternitz M. D. | Sinai Hosp. Balto. Md. | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 25 1949 | Hebrew Friend Ship | Philadelphia Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | David Sondheim | 1902 Eutaw Pl |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679246 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): GLADYS LEWIS

2. DATE OF DEATH: 10/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
C. Length of stay in Baltimore: Yrs. 2 — Mos. — Days —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Willards
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | JULY 12. 1919 | 30 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H. W. | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Levin Leighton | Elizabeth |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Husband | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive atelectasis of

DUE TO

(B) Septicemia (over)

DUE TO

(C) Rectal Bleeding

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/5/49 | Nothing | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/4, 1949 *to* 10/25, 1949, *that I last saw the deceased alive on* 10/25, 1949, *and that death occurred at* 9:35 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nicholas Mallis M. D. | Univ. Hosp | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10/26/49 | New Hope | Willards Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Registrar for Williams, Md | Ulman Funeral Home | Pocomoke |

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G79247

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79247

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Leonora M.Holthause

2. DATE OF DEATH: 10-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1310 E.Lafayette Avenue
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Marylend
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1310 E.Lafayette Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 5-4-1869
9. AGE (In years last birthday): 80 — If under 1 Year: Months 5, Days 20; If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore,Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Michael Tyrll
14. MOTHER'S MAIDEN NAME: Margaret Kirby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs.Edward H.Holthause — ADDRESS: 900 N.Franklintown Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Hypostatic Pneumonia — 4 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 19 *to* Oct 23 1949 *that I last saw the deceased alive on* 10/22 1949 *and that death occurred at* 9:55 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 100 W. Mulberry
23C. DATE SIGNED: 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-27-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Frederick Rd.Balto:Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1C
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: George J.Ruth, Inc., — ADDRESS: 1735 Harford Avenue

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Medical Examiner's Release

G79248

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79248

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Frank Jacob

2. DATE OF DEATH: October 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland I400 N.Caroline St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D. O. A. (St Joseph's Hospital)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-07
D. STREET ADDRESS (If rural, give location): 1748 Carswell St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | I-30-I893 | 56 | 8 / 25 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bottling Department | Gunther's Brewery | Baltimore, Maryland | |

13. FATHER'S NAME: Frank A.Jacob

14. MOTHER'S MAIDEN NAME: Kate Maker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | None | 215-10-9226 | Mrs.Mary V.Jacob-I748 Carswell St,Balto:Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary arteriosclerosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertension

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

R B Fisher M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/18/ , 1949 *to* 10/24/ , 1949, *that I last saw the deceased alive on* 10/24/ , 1949 , *and that death occurred at* m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Sawinski M. D. | 1400 N. Caroline Street | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | I0-29-I949 | Morelands Park | Taylor Ave Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 10/31/49 | Huntington Williams M.D. | George J.Ruth,Inc.I735 Harford Avenue |

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79-249

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 2001

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martin HEATH

2. DATE OF DEATH: 22 OCT. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore: Yrs. LIFE Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D STREET ADDRESS (If rural, give location): 6710 BOSTON AVE.

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 8/26/1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | U.S.A. |

13. FATHER'S NAME: ARTHUR HEATH

14 MOTHER'S MAIDEN NAME: HANNA GABLER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | ? | VERA HEATH | 6710 BOSTON AVE. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Retroperitneal Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 30 Sept 1949 | Retroperitneal Lympho sarcoma | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 15 Sept, 1949, *to* 22 OCT, 1949, *that I last saw the deceased alive on* 22 OCT, 1949, *and that death occurred at* 7:25 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irving Seleski's M. D. | Sinai Hospital | 22 OCT '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/26/49 | OAKLAWN | BALTO. CO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Lurington Williams, M.D. | WILLY & ZEILER INC. | BALTO. MD. |

VS 150

46H

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. 679250

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679250 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the causes of death clearly and legibly. Especially important. Please write the correct age in each case.

1. NAME OF DECEASED (Type or Print): FREDRICK SCHNEIDER
2. DATE OF DEATH: Oct. 24, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
   B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 208 N. KENWOOD AVE
   C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
   A. STATE: MARYLAND
   B. COUNTY
   C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 6-02
   D. STREET ADDRESS (If rural, give location): 208 N. KENWOOD AVE
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Oct. 10, 1877
9. AGE (In years last birthday): 72 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: George W. Schneider
14. MOTHER'S MAIDEN NAME: Louisa KERNER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 219-14-1239
17. INFORMANT: Mrs. Florence Schneider ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 5 weeks |
| DUE TO (B) | Generalized Arteriosclerosis | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hemiplegia - right | 2 weeks |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 14, 1949, *to* Oct 24, 1949, *that I last saw the deceased alive on* Oct 22, 1949, *and that death occurred at* 6 00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lionel Bill M. D.
23B. ADDRESS: 1221 N Luzerne Ave
23C. DATE SIGNED: Oct 24 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 27 1949
24C. NAME OF CEMETERY OR CREMATORY: Oakdawn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran ADDRESS: 3000 E. Balto St. Balto. 24. Md.

VS 150

838

MARGARET C WAGNER ✓ G79251

G79251

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Margaret C. Wagner

2. DATE OF DEATH: 10-24-79

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4115 Gradeaue Ord GRAHAME
c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Ba 12-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2919 Huntingdon Ave

5. SEX: Fem
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 7.19.1903
9. AGE (In years last birthday): 46 — Under 1 Year: Months 3, Days 5, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Portsmouth Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Foley
14. MOTHER'S MAIDEN NAME: ?

15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: daughter ADDRESS: 4115 Gradeaue Ord Ft. Lauderdale

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 Days

DUE TO

(B) Hypertensive Cardiac Vascular disease — 2

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 10.23.79 to 10.24.79, that I last saw the deceased alive on 10.23.79 and that death occurred at 9:15 a.m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1048 Overlea Blvd
23C. DATE SIGNED: 10.24.79

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 27-1979
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Baltimore Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 29
REGISTRAR'S SIGNATURE: [signature] Washington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

VS 150

93D

G79252 ✓ G79252

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | ANNA LEE SHAW |
| 2. DATE OF DEATH | 10-23-49 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2314 Poplar Grove Street |
| C. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 15-47 |
| D. STREET ADDRESS (If rural, give location) | 2314 Poplar Grove Street |
| 5. SEX | Female |
| 6. COLOR OR RACE | White |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | Single |
| 8. DATE OF BIRTH | 1876 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min. | 73 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Cashier |
| 10B. KIND OF BUSINESS OR INDUSTRY | Greyhound Bus. Term. |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | James Shaw |
| 14. MOTHER'S MAIDEN NAME | Anne Carroll |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | No. |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT / ADDRESS | Mr. Jas. Shaw 2314 Poplar Grove |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxaemia due to general carcinomatosis. — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO

(B) Carcinoma of sigmoid — INTERVAL BETWEEN ONSET AND DEATH: about 2 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | |
|---|---|
| 19A. DATE OF OPERATION | May 1948 |
| 19B. MAJOR FINDINGS OF OPERATION | Carcinoma of sigmoid |
| 20. AUTOPSY? | YES ☐ NO ☑ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | — |
| 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | — |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) | — |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | — m. |
| 21E. INJURY OCCURRED | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ |
| 21F. HOW DID INJURY OCCUR? | — |

22. *I hereby certify that I attended the deceased from* Jan 7, 1948, *to* Oct 23, 1949, *that I last saw the deceased alive on* Oct 22, 1949, *and that death occurred at* 2:10 A.M. *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| [illegible] M. D. | 2200 GARRISON BLVD. [illegible] | 10-24-49 |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
| Burial | 10-26-49 | Cathedral | City |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| OCT 25 1949 | [illegible] Registrar for Baltimore, Md. | WIEDEFELD AND SON | GREENMOUNT AVE. & 22nd ST. |

VS 150

46E

G79253 ✓ G79253

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49 ✓ Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Ellis

2. DATE OF DEATH: 10/23/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1518 Druid Hill Avenue

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1518 Druid Hill Avenue

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 6/10/1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Baltimore City
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Mary Lewis ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Brown — ADDRESS: 807 N. Calhoun St.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) primary atypical pneumonia — DUE TO — 7 days

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) None — DUE TO

(C) none

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. none

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9- 1949 *to* 10-25, 1949 *that I last saw the deceased alive on* 10-23, 1949, *and that death occurred at* 1:35 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: James D. Carr, M. D.
23B. ADDRESS: 1827 Madison Ave
23C. DATE SIGNED: 10-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/26/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: 10/25/1949
REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantly Avenue

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

109a

G79-54 G79-54

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) FLORENCE LANE 023

2. DATE OF DEATH October 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-06
D. STREET ADDRESS (If rural, give location) 1502 Oliver Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | colored | Widow | 1/4/1898 | 51 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore City | U.S.A. |

13. FATHER'S NAME William Flemings

14. MOTHER'S MAIDEN NAME Elizabeth Flemings

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| No | | |

17. INFORMANT ADDRESS Florence Mitchell 1502 E. Oliver St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Senile Senility

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Long M.D. | | October 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/1949 | Mt Calvery Cem. | Brooklyn A A.Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 25 1949 | Huntington Williams, M.D. | Elroy C. Wilson 1000 Brantly Avenue |

VS 151

30

AB-132650
G79255

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 16 210 G79255

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Baby Girl Freeman

2. DATE OF DEATH: 10-20-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 929 Shields Place 17-01

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 15- 1949
9. AGE (In years last birthday): If Under 1 Year — Months: . Days: 5; If Under 24 Hours — Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Gladys Freeman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records: Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fetal Atelectasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-15- , 1949 *to* 10-20- , 1949, *that I last saw the deceased alive on* 10-20- , 1949, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 9AM 10-22-1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore City Hospitals
24D. LOCATION (City, town, or county) (State): 4940 Eastern Avenue, Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

161a

G79256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

53

G79256

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Stephen Lee

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1725 Bolton St. 14-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | MAR. 5, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Real Estate Owner. | Real Estate. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Julian Henry Lee

14. MOTHER'S MAIDEN NAME: Elizabeth Tyson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | Not Known | Miss H. Wallace | Church Home Hospital |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Mesenteric ARTERIAL Thrombosis | 48 hrs |
| DUE TO (B) | Operative resection of carcinoma of colon with end-to-side ileo-colostomy | 72 hours |
| (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Generalized Arteriosclerosis | 30 years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/22/49 | Carcinoma of Transverse Colon | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/12/49, 19__, *to* 10/25, 1949, *that I last saw the deceased alive on* 10/25, 1949, *and that death occurred at* 1:52 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. M. Howard, M.D. | Church Home and Hospital | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49. | Green Mount | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Tallhorn & Son | 1700 Eutaw St |

VS 150

46E

G79257 X ✓ 770.0 G79257

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-29218 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. NAME OF DECEASED (Type or Print): Buerhaus

2. DATE OF DEATH: Oct. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 213 Trappe Rd. # 22

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Oct. 19, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 10

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Andrew Buerhaus
14. MOTHER'S MAIDEN NAME: Melba Merle Stump

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: 213 Trappe Rd. # 22

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hydrops and erythroblastosis fetalis | ? 2 weeks |
| DUE TO (B) | Rh sensitization of mother | more than 4 weeks |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 19, 1949, *to* Oct 19, 1949, *that I last saw the deceased alive on* Oct 19, 1949, *and that death occurred at* 1:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Irene H. Kaiser, M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): OCT 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

161c

G79258

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-21552

Registered No. G79258

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Important. correct age is especially

1. NAME OF DECEASED (Type or Print): Baby Girl McWilliams

2. DATE OF DEATH: Oct. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore (Yrs. Mos. Days): 8 minutes

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 209 N. Ellwood Ave. 6 01

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Oct. 6, 1949
9. AGE (In years last birthday) If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min. 8

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lloyd Wilbur McWilliams
14. MOTHER'S MAIDEN NAME: Crystal Lorraine Rehberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: mother ADDRESS: 209 N. Ellwood Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HYDROCEPHALUS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 6 1949 *to* Oct 6, 1949 *that I last saw the deceased alive on* Oct. 6, 1949, *and that death occurred at* 9:55 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry M Cushman M. D.
23B. ADDRESS: Sinai Hospital Balto.
23C. DATE SIGNED: 10-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS
24D. LOCATION (City, town, or county) (State): OCT 24 1949

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

157a

G79259 ✓ G79259

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Hazel WHITTEN (Mrs.)
2. DATE OF DEATH: Oct. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1422 S. Hanover St. 23-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Divorced | 3/15/1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waitress | Tavern | Maryland. | USA. |

13. FATHER'S NAME: Frances T Crockett
14. MOTHER'S MAIDEN NAME: Sarah R. Cross

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | 216-16-5828 | Mr. H. S. Crockett | 3601 Elrador Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute alcoholism
DUE TO
(B) Chronic alcoholism
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X] *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 24, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/49 | London Park | Frederick Ave Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John F Kenny Inc
ADDRESS: 715 Light St

VS 151

77D

Med. Exam. case

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 679x50

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Willie Graham 243463

2. DATE OF DEATH: OCT 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Ward, Room

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. - Mos. - Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 206 Aisquith St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | ? 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | ? | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Walter Graham ? | Effie McNeil ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL Gladys Graham | 206 Aisquith St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASTHMA

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Years

CERTIFICATION APPROVED BY
R. Ruben
For: C. J. Lubinski, M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Warren E. Porter M. D. | JOHNS HOPKINS HOSPITAL | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/49 | Mt. Auburn Cem. | West Post Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Hunting for Williams, M.D. | Metropolitan Funeral Home | 2211 N. Mount St |

VS 150

Released to Hospital

112

G79261 Jan 15741

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

491 G79261 Registered No.

BIRTH NO.

RELEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Johanna Frazier

2. DATE OF DEATH: Oct.22,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 75 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): No address- B. C. H. Infirmary

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Single | ? ? ? | 84 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Germany | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B. C. H. Records, | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchopneumonia | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis General | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* May 7, 1914 *to* Oct. 22, 1949 *that I last saw the deceased alive on* Oct.22, 1949 *and that death occurred at* 3.30pm, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rosen M. D. | 4940 Eastern Ave. | 10-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/49 | Sacred Heart | Germantown Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | J. Staley Long | 107 |

VS 150

679262

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

171 Registered No. 679262

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): PAULINE D. CHANEY

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 708 Pontiac St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 708 Pontiac St. 25-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Jan. 6, 1908 | 41 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Baltimore, Md. | |

13. FATHER'S NAME: Michael Travinsky

14. MOTHER'S MAIDEN NAME: Pauline ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| none | | Mr. William E. Chaney | 708 Pontiac St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Metastases of the Brain | |
| DUE TO (B) | Carcinoma of Cervix Uteri | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/24, 1949 *to* 10/25, 1949 *that I last saw the deceased alive on* 24 Oct, 1949 *and that death occurred at* 4:20 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis McGratty M. D. | 1 E Randall St | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | Cedar Hill Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

48a

679283

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. 679283

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): EDGAR WELLS FISHER

2. DATE OF DEATH: Oct. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2153 Mt. Holly St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2153 Mt. Holly St. 15-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Aug. 26, 1890 | 59 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| President | Paper company | Baltimore .Md. | |

13. FATHER'S NAME: Edgar Fisher

14. MOTHER'S MAIDEN NAME: Emily Wells

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Ethel Y. Fisher | 2153 Mt. Holly S |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Recurrent Coronary Thrombosis with congestive failure | 30 minutes |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | | |
| DUE TO (C) | Coronary Thrombosis | 9/15/49 |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | none | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 13, 1949, *to* Oct 24, 1949, *that I last saw the deceased alive on* Oct. 24, 1949, *and that death occurred at* 6:00 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maurice E. Thames M. D. | 3300 W. Forth ave, | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

94a

679-54

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17° Registered No. 679-54

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH MOSKOWITZ

2. DATE OF DEATH: 10-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5717 Oakshire Road
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-19
D. STREET ADDRESS (If rural, give location): 5717 Oakshire Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Israel

14. MOTHER'S MAIDEN NAME: Rehanna

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Meyer Kushnick | 5717 Oakshire Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Breast | 1 Yrs. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1948 | Carcinoma of Breast | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 20 1949 *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 26, 1949, *and that death occurred at* 3:40 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Carl E. Carlin M.D. M. D. | 2242 South Road | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
|---|---|---|---|---|
| Burial | 10-26-49 | Hebrew Friendship | Balto | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79265

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

200.1

G79265

BIRTH NO.

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Beulah K. Lynch

2. DATE OF DEATH October 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland X

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

C. Length of stay in Baltimore Yrs. Resident Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 12 27 - 48
D. STREET ADDRESS (If rural, give location) 528 Tunbridge Rd.

5. SEX W F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 8 Sept '84
9. AGE (In years last birthday) 65 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nicholas Kirby
14. MOTHER'S MAIDEN NAME Mahalah Bryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Husband ADDRESS Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lymphosarcoma retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
DUE TO LYMPHOSARCOMA RETROPERITONEAL

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-15, 1949 *to* 10-25, 1949 *that I last saw the deceased alive on* 10-25, 1949 *and that death occurred at* 12:25 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE Wm. M. Kunkel, M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 10-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-28-49
24C. NAME OF CEMETERY OR CREMATORY Parkwood
24D. LOCATION (City, town, or county) Balto. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 4905 York Rd

VS 150

46 H

G79216 BALTIMORE CITY HEALTH DEPARTMENT G79216
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print): Benjamin Klasmer
2. DATE OF DEATH: October 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 40 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4100 Fairview Ave 15-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 16, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Musical Contractor | Hippodrome Theatre | Austria | USA. |

13. FATHER'S NAME: Mendel Klasner
14. MOTHER'S MAIDEN NAME: Maita ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Sadie Klasmer ADDRESS 4100 Fairview Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | acute coronary occlusion | 10 min. |
| DUE TO (B) | arteriosclerotic heart disease | 1 year |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
R. H. Fraser
For William Kammer M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 1949, to October, 1949, *that I last saw the deceased alive on* 10/15/1949, *and that death occurred at* 12:40 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Friedman M. D. | 1737 E. North Avenue | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-26-49 | Hebrew Washington Blvd | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

937

PLEASE WRITE LEGIBLY WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G7924,7

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 1

G7924,7

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. NAME OF DECEASED (Type or Print) CHARLES GARDNER

2. DATE OF DEATH October 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
620 Sarah Anne Street 4-0-W

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | | | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obliterative coronary sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hemaplegia due to former cerebral thrombosis

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Oct. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-26-49 | Mt. Albion Cemetery | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | William A. Jackson 916 Penna. Ave. |

VS 151

94a

679218

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679218

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Raye B. Loeb

2. DATE OF DEATH 10-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Women's Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hospital for Women of Maryland
c. Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15
D. STREET ADDRESS (If rural, give location) 5833 Park Heights Ave. 27-19

5. SEX 7
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 8-7-85
9. AGE (In years last birthday) 64 — If under 1 Year: Months 2, Days 18 — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) York, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Henry Bailey
14. MOTHER'S MAIDEN NAME Henrietta [redacted] Katzstein
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO
17. INFORMANT Joseph Loeb — ADDRESS 5833 Park Hgts. Ave. Baltimore 15, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Occlusion | 48 hrs. |
| DUE TO (B) | Arteriosclerotic Heart Disease | 5 years |
| DUE TO (C) | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE John R. Smith Jr. M. D.
23B. ADDRESS Hosp. for Women of Md.
23C. DATE SIGNED 10-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Oct 27 1949
24C. NAME OF CEMETERY OR CREMATORY Hebrew Friend Shij
24D. LOCATION (City, town, or county) (State) Philadelphia Pa

DATE RECEIVED BY LOCAL REGISTRAR OCT 26 1949
REGISTRAR'S SIGNATURE [illegible] Interington Williams, M.D.
25. FUNERAL DIRECTOR David Sondheim Sons
ADDRESS 1902 Eastern Ave

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79-2:9 ✓ E 981.° G79-2:9

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. N-8624

1. NAME OF DECEASED (Type or Print): DANIEL WALKER

2. DATE OF DEATH: 10-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen. Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 612 Hillsview Road 25-3 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | April 8, 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Factory | Weldon N.C. | U.S.A. |

13. FATHER'S NAME: Matthew Walker
14. MOTHER'S MAIDEN NAME: Mary Ransom

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Mary Walker | 612 Cheery Hill Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage due to gunshot wound
DUE TO of chest and abdomen
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE~~ OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 612 Hillsview Rd. |
|---|---|---|
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 22, 1949 a. m. | 21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? Firearms (shot during altercation) |

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Paul L. Pryse M.D. | | Oct. 22, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-26-1949 | Mt Calvary Cem. | Cedar Hill Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Registrar Williams, M.D. | Mrs Katie R. Williams | 3224 Edmondson Ave |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 151

166 ✓

G79270 D.O.A. G79270

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

340 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carl Diggs JR.

2. DATE OF DEATH: 10-24- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Baltimore City Hospital
c. Length of stay in Baltimore: Life ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 639 N. Calhoun ST.. 16-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | S | Aug. 24, 1949 | | 2 | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.,
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Carl Diggs.
14. MOTHER'S MAIDEN NAME: Virginia Trusty.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records Balto. City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Meningitis – E Coli | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
H S Fisher
For: Wm. G. Helfrich M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* D.O.A. , 19 , *to* D.O.A. , 19 , *that I last saw the deceased alive on* D.O.A. , 19 , *and that death occurred at* D.O.A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Rozen M. D. | B.CH. 4940 Eastern Ave. | 10-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-26-1949 | Mt. Auburn | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams M.D. | Mrs Katie R Williams | 3224 Lehrock Ave |

VS. 150

To Be Approved By The Chief Medical Examiner. 8/0

PLEASE WRITE PLAINLY IN INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79271 G79271

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Shirley Spraggins

2. DATE OF DEATH: Oct. 25 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 240 Pine St. 4-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro. | WIDOWED(?) | Feb. 1894 | 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam Spraggins

14. MOTHER'S MAIDEN NAME: Nigie Comer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Anna Martin ADDRESS: 1118 W Lafayette Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio Vascular Disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 24, 1949, *to* Oct. 25, 1949, *that I last saw the deceased alive on* Oct 25, 1949, *and that death occurred at* 8:35 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Patterson Mach M. D.

23B. ADDRESS: University Hospital, Balto

23C. DATE SIGNED: 10-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10-29-1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Katie R Williams ADDRESS: 322 N Schroeder St.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79272

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79272

BIRTH NO. 132872

1. NAME OF DECEASED (Type or Print): Joseph ,Moulden

2. DATE OF DEATH: 10-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2438 Druid Hill Ave. 13-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Widowed | ? | 78 ? | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records Balto City Hospitals ADDRESS: 4940 Eastern Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Gangrene Of Right Foot
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24-49, 19__, *to* 10-25-, 1949, *that I last saw the deceased alive on* 10-25, 1949, *and that death occurred at* 6.10 AM *from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 10-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-28-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Kate R Williams ADDRESS: 332 N Schroeder St

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79273

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 49

Registered No. G79273

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KING, Clarence

2. DATE OF DEATH: 10-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. 18 Mos. 01 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 405 N. Schroeder St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | Aug. 10, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Porter | Easco Electric Co. | Balto. Md | U.S.A. |

13. FATHER'S NAME: Alexander Briggs

14. MOTHER'S MAIDEN NAME: Mollie King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ollie King ADDRESS: 405 N. Schroeder St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Hypertensive C V Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23, 1949 *to* 10-23, 1949 *that I last saw the deceased alive on* 10-23, 1949, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: James M. Bisanar M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 10-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10-27-1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Pk

24D. LOCATION (City, town, or county) (State): Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Katie R Williams

ADDRESS: 3224 Edmondson Ave

VS 150

937

679274

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 ✓ 679274 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles P. Rousom

2. DATE OF DEATH: 10-24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2407 E. Preston St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2407 E. Preston St 5-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year, last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Aug-15-1853 | 96yrs | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Balto. Md. | |

13. FATHER'S NAME: Jacob Rousom

14. MOTHER'S MAIDEN NAME: Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Margaret P. Ford ADDRESS: 2407 E. Preston St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Glomerular Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
arteriosclerosis — 20 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 1/15, 1941 to 10/24, 1949 that I last saw the deceased alive on 10/24, 1949 and that death occurred at 8 P. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Karl Grossman M. D. | 1217 N. Patterson Park Ave | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-27-49 | Baltimore Cem | North Ave - Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | John C. Millspaugh Inc. | 2433 E. Oliver St |

VS 150

131a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79275

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0 G79275 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William P. SLOUGH (emw)

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1205 Union Ave. 13-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | W | July 19 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Livingston Mkt. | Va | |

13. FATHER'S NAME: John Slough

14. MOTHER'S MAIDEN NAME: Lucy Hartless

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Ella Slough | 1205 Union Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of esophageal varix

DUE TO

(B) Cirrosis of Liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER X MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Oct. 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | Woodlawn | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Paul E. Lemmon | 3405-17 Chestnut Ave. |

VS 151

124B

CORRECTIONS WILL NOT BE MADE, WITH UNEXPLAINED ENTRIES. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

079276

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. 079276

1. NAME OF DECEASED (Type or Print): Rev. John Joseph Fleckenstein, CSSR
2. DATE OF DEATH: October 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 174 Diamond Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | March 17, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Religious (Priest) | Religious | Baltimore, Maryland | |

13. FATHER'S NAME: Peter J.Fleckenstein
14. MOTHER'S MAIDEN NAME: Wilhelmina Brenneis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | None | None | Mrs. Wilhelmina Fleckenstein | ~~3814 Baterie Ave, Balto:Md.~~ |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/28/ , 1949 *to* 10/25/ , 1949, *that I last saw the deceased alive on* 10/25/ , 1949, *and that death occurred at* 9:45 AM, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Theodore Siwinski M. D. | 1400 N. Caroline Street | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-29-49 | Most Holy Redeemer Cemetery | Philadelphia Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Winterton Williams, M.D. | George J. Ruth, Inc. - 1735 | Harford Ave. Balto:Md. |

VS 150

828

G79277 X ✓ 120.0 G79277

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HARRY CLEVELAND TEE

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Delaware
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harrington
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 9/1/95 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Del. | USA |

13. FATHER'S NAME: Oscar Tee

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | 221-09-9447 | Records- US Marine Hospital | Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Edema, pulmonary, due to circulatory disturbance | Unknown |
| DUE TO (B) | Arteriosclerotic heart disease | Unknown |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Hypertensive cardiovascular disease | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 24, 1949, *to* Oct. 25, 1949, *that I last saw the deceased alive on* Oct. 25, 1949, *and that death occurred at* 10:15PM, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-29-49 | Hollywood | Harrington Del |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Mrs R. W. Boyer | Harrington Del |

VS 150

937

Please write clearly with pen and ink. Every item must be answered. Information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79278

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

143 Registered No. G79278

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Crooks

2. DATE OF DEATH: 10/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore - 29
D. STREET ADDRESS (If rural, give location): 610 Cook's Lane 78-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W | Widowed | 3-11-1877 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Matthew Fentzel - dec'd
14. MOTHER'S MAIDEN NAME: Dorothy Sanderson - dec'd.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Thelma L. Acker ADDRESS: 610 Cook's Lane

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal pneumonia, Hypostatic
DUE TO
(B) Arteriosclerotic Hypertensive CVD
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/16 1949 *to* 10/25, 1949 *that I last saw the deceased alive on* 10/25, 1949, *and that death occurred at* 4 45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert J. Dickas M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 10/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Oct 28/49
24C. NAME OF CEMETERY OR CREMATORY: Plum Creek
24D. LOCATION (City, town, or county) (State): New Texas - Pa.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Mus. John W. Teufel & Son ADDRESS: 5311 Edmondson Ave

VS 150

937

G79279 ✓ × G79279

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Charles C. Coulson
2. DATE OF DEATH: 10/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore – 6 Rosedale
D. STREET ADDRESS (If rural, give location): 1618 Rosedale Heights Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 3/23/1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shipping Clerk | General Electric | Maryland | U.S.A. |

13. FATHER'S NAME: John Coulson
14. MOTHER'S MAIDEN NAME: Sophie Emroff ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown no | 216-09-8426 | Ruth Coulson | 1618 Rosedale Heights |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Syphilitic aortic, DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) abdominal, aneurysm DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/17, 1949 *to* 10/24, 1949 *that I last saw the deceased alive on* 10/24, 1949 *and that death occurred at* 8:35 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert L. Hicks M. D. | St. Agnes Hospital | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 27. 1949 | London Park | Baltimore Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Mrs. Mrs. John W. Tuffel-Son | ADDRESS: 5311 Edmondson Ave

30 ✓

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79280 ✓ 401 ✓ G79280

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marion Elmer Ellerbe

2. DATE OF DEATH: OCT 22 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-0 ✓
D. STREET ADDRESS (If rural, give location): 1208 E. Madison St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | Child | 2-10-39 | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md | |

13. FATHER'S NAME: William Ellerbe

14. MOTHER'S MAIDEN NAME: Ella Joyner ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart Failure — (INTERVAL BETWEEN ONSET AND DEATH) 4 wks

DUE TO

(B) ? Rheumatic Myocarditis

DUE TO

(C) (over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NO | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-25 1949 *to* 10-22 1949, *that I last saw the deceased alive on* 10-22, 1949 *and that death occurred at* 940 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James L. Gamble Jr. M. D. | JOHNS HOPKINS HOSPITAL | 10/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/26/49 | Mt Calvary Cem | A. A. Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Rayner Sanders 1412 E Preston St 5tc |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79281 ✓ E917.0 G79281

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. G79281

BIRTH NO. 11-94507

1. NAME OF DECEASED (Type or Print) DONALD WILSON — N-948.5

2. DATE OF DEATH 10/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) PROVIDENT HOSPITAL
C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 17-0
D. STREET ADDRESS (If rural, give location) 1126 WILMER CT.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | SINGLE | 7/29/27 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | Infant | Balto Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| EDWARD WILSON | IVEZ EDGERTON |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | NONE | MOTHER | 1126 Wilmer Ct. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO (B) 1st & 2nd DEGREE BURNS OF — 11 days

DUE TO (C) 90% BODY SURFACE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY

CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| NONE | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| ACCIDENT | HOME | 1126 Wilmer Ct. 17/2 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10/13-49 9 p.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Scalded Backed up into tub full of hot water |

22. *I hereby certify that I attended the deceased from* 10/13 1949 *to* 10/24 1949, *that I last saw the deceased alive on* 10-24 1949, *and that death occurred at* 11:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Provident Hospital | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/49 | Arbutus Memorial Pk. | Balto County Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Chas. H. Orpe | 512 Eastern Ave |

VS 150

181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79282

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

G79282

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Conrad M- Seubott

2. DATE OF DEATH: Oct. 24-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 321-Mt. Holly Street

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 321-Mt-Holly-Street.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct-9-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Prop. - C-M. Seubotth. | "Monuments." | Baltimore - Md. | USA |

13. FATHER'S NAME: Michael - Seubott

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Irene M. Seubott. | - Same - |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 18, 1949, to Oct 24, 1949, *that I last saw the deceased alive on* Oct 25, 1949, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE AND M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. S. Sargent, M. D. | 1729 W. Lombard St | Oct 26 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 27 '49 | New Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | C. J. Wilbert & Son | 1300 Eutaw St |

VS 150

94a

correct age, is especially important. Physicians: please write the cause of death clearly and legibly.

G79283 G79283

BIRTH NO. 49-21471

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Philip R. Wisner

2. DATE OF DEATH: 10-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 18 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balt
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | 10-5-49 | | 20 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James R. Wisner | Anne Van Gunter |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 18-20 d.
DUE TO
(B) malrotation of intestine — 18-20 d.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
cyanosis - atelogy ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| ① 10-7-49 ② 10-23-49 | ① malrotation ② adhesions ③ adhesive bands | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-7, 1949, *to* 10-25, 1949, *that I last saw the deceased alive on* 10-25, 1949, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. F. Brooddus M. D. | University Hosp | 10-26 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 27 1949 | Pleasant Hill | Owings Mills, Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Wm. Berryman & Sons Registration |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1226

G79284 G79284

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Dr Ball 49-22910 — 776 — Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hargett

2. DATE OF DEATH: 10-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2025 W. Fayette St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: 21 Hrs. 15 Min. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 23.
D. STREET ADDRESS (If rural, give location): 2115 W. Baltimore St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Single | 10-25-49 | | | 21 / 15 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Edward Hargett
14. MOTHER'S MAIDEN NAME: Dolores June Dormon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-25 19 49 *to* 10-26 19 49 *that I last saw the deceased alive on* 10-26 19 49 *and that death occurred at* 4 35 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. D. Sylvan Jr. M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 10-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 10/27/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Thomas J. Kenny Inc. ADDRESS: 1602 Hollins St 1596

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79285 ✓X G79285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

776 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby "Boy" Olyszczak

2. DATE OF DEATH: OCT 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Forest Hill
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | 10-25-49 | | | 1 | 24 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alexander Olyszczak

14. MOTHER'S MAIDEN NAME: Ann ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-25- , 1949, *to* 10-26 , 1949, *that I last saw the deceased alive on* 10-26, 1949, *and that death occurred at* 6:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Irene Blunden M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED:

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct 27-49 | W. M. Mathews Mem. | Forest Town Harford | Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Martin L. Kenny ADDRESS: Jarrettsville Md

159

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

✓ T & R approved

G79286

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E921.0

G79286

Registered No.

BIRTH NO. 49-21413

N-933

1. NAME OF DECEASED (Type or Print): MARK EDWARD WHITESELL

2. DATE OF DEATH: OCT 26, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL
c. Length of stay in Baltimore: Yrs. 38 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE, MD. 13-07
D. STREET ADDRESS (If rural, give location): 4058 HICKORY AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | SEPT 18, 1949 | | / 38 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | BALTIMORE, MD. | |

13. FATHER'S NAME: CLARENCE E. WHITESELL

14. MOTHER'S MAIDEN NAME: MARJORIE E. SANDERS

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Clarence E. Whitesell — ADDRESS: 4058 Hickory Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | ASPHYXIATION | 1 Hr. |
| DUE TO (B) | ASPIRATION OF STOMACH CONTENTS | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | PYLOROSPASM | 20 M. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
For: Wm. G. Helfrich, M.D.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | R S Fisher M. D. (OFFICE OR ASST. MEDICAL EXAMINER) | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accidental | home | 4058 Hickory Avenue |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 26, 1949 ? a. m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Aspiration of stomach contents 13/7 |

22. *I hereby certify that I attended the deceased from* Oct. 18, 1949 *to* Oct. 26, 1949 *that I last saw the deceased alive on* Oct 26, 1949 *and that death occurred at* 8 a.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mary E. Hayleck M. D. | 229 E. 33rd St. | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 27 1949 | Lorraine Park | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 1949 | Huntington Williams, M.D. | Burgee Funeral Home | 3631 Falls Road |

VS 150

195 D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79287

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 578

BIRTH NO. | Registered No. G79287

1. NAME OF DECEASED (Type or Print): Estelle Mary Riggs
2. DATE OF DEATH: 10-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore - Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for Women of Maryland.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1911 N. Calvert. 12-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | Feb. 22, 1885 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reg. Nurse
10B. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Gloucester, Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Riggs
14. MOTHER'S MAIDEN NAME: Mary McFadden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: patient — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gastro intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: ? 36 hours
DUE TO
(B) Cause Un Known

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
a) Diabetes Mellitus — a) 7 years
b) Hypertensive Cardio vascular disease — b) Unknown
c) Pyonephrosis — c) Unknown

19A. DATE OF OPERATION: 10-19-49
19B. MAJOR FINDINGS OF OPERATION: diabetic gangrene of left foot.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 10-18, 1949, to 10-26, 1949, *that I last saw the deceased alive on* 10-26, 1949, *and that death occurred at* 1 42 a.m./p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Medical Director Robert L. Dill M.D.
23B. ADDRESS: Hosp. For the Women of Md. Baltimore
23C. DATE SIGNED: 10-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/29/49
24C. NAME OF CEMETERY OR CREMATORY: Cherry Hill
24D. LOCATION (City, town, or county) (State): Gloucester Mass

DATE RECEIVED BY LOCAL REGISTRAR: OCT 26 1949
REGISTRAR'S SIGNATURE: Livingston Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: J. J. Fahey Sons 1318 Eutaw

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79288 ✓4 G79288

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 4.1 Registered No.

1. NAME OF DECEASED (Type or Print): IVORY DONALD COLLEY 20
2. DATE OF DEATH: Oct 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. MARINE HOSPITAL
C. Length of stay in Baltimore: 34 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: VIRGINIA
B. COUNTY: BADEN
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BADEN
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | SINGLE | Oct 8, 1923 | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SEAMAN | AMERICAN SEAMAN | VIRGINIA | USA |

13. FATHER'S NAME: CAMPBELL COLLEY
14. MOTHER'S MAIDEN NAME: TALMIRA DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): US MERCHANT MARINE
16. SOCIAL SECURITY NO: UNKNOWN
17. INFORMANT: MOTHER — ADDRESS: BADEN, VA

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) MYELOGENOUS LEUKEMIA | 2 YRS 4 MOS |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 25, 1949, *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 26, 1949 *and that death occurred at* 1:45 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert [illegible] M.D. | U S Marine Hosp. Balt. Md | Oct 26 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | Baden | New Abington Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT-27 1949 | [illegible] Williamsville, Md | [illegible] | [illegible] |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

74a

G79289 ✓x G79289

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NORA DIXON.

2. DATE OF DEATH: 10.27.49.

3. PLACE OF DEATH: A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL,

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND. B. COUNTY: Leonett
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE. OAKLAND.
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White. | MARRIED. | 11.28.1882. | 66 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE. | — | MARYLAND | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? RILEY. | ALICE VAN SICKLE. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRO VASCULAR ACCIDENT.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11 AM. 10/25/49 to 10.27. 1949 *that I last saw the deceased alive on* 10/26/ 1949 *and that death occurred at* 11.20 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. M. Garrett M.D. M. D. | Church Home & Hosp. | 10/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | Bloomingrose | Friendsville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Huntington Williams, M.D. | Wilson Cook Inc | 1219 Eutaw St |

VS 150

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79250 ✓ G79250

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH ✓

BIRTH NO. Registered No.

E 80 N-8047

1. NAME OF DECEASED (Type or Print): PETER LEONARD SZEWC

2. DATE OF DEATH: October 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 3307 Southern Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days:

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 28, 1917 | 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Welder | Md. Drydock | Dixon City, Pa. | |

13. FATHER'S NAME: Micheal Szewc

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Mary Szewc — ADDRESS: 3307 Southern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushing injuries of head and body — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ■

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Son Park Sinclair Lane between Gay St. & Patter-

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 26, 1949 1p. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Run over by train

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: R S Fraber M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: October 27, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10-31-49 | Dixon City, Pa. | |

DATE RECEIVED BY LOCAL REGISTRAR: 10-27-1949

REGISTRAR'S SIGNATURE: Interim Registrar Williams, M.D.

25. FUNERAL DIRECTOR: Lanahan Funeral Home — ADDRESS: 7401 Belair Rd.

VS 151

169

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G79291

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79291

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES SAVAGE 450 | 2. DATE OF DEATH: October 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): 205 East Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Single | 7-10- | 40 (dim) | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| VENDOR | SELF | N.C | |

13. FATHER'S NAME: Charles Savage
14. MOTHER'S MAIDEN NAME: Minnie Goodmon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Juanita Savage | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Rupture, splenic Artery | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerosis | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* _____ *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *and death in my opinion resulted from: natural causes* ☐, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal 1949 | 10-28-49 | Drum Hill | N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 10-27-49 | for Williams, M.D. | Joseph B. Locke, Jr. | 1304 N. Central Ave |

VS 151 2-7-79

97

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79292 ✓ G79292

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-22651 Registered No. 0

1. NAME OF DECEASED (Type or Print): Baby Girl Zeigler — 2. DATE OF DEATH: 10/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland ✓
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 6700 Reisterstown Road.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Infant | 10-20-49 | | | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland. | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: Mary Zeigler.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Immature, Prolonged Atelectasis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/20, 1949 *to* 10/21, 1949, *that I last saw the deceased alive on* 10/21, 1949, *and that death occurred at* 9:30 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. N. D'Elia Jr. M. D. | St. Agnes Hosp | 10/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/27/49 | Cathedral | Balto-Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 26 | [illegible] | M. Faher & Sons | 1827 W. North Ave. |

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

161a

G79293

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 456

G79293

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Hester Williams

2. DATE OF DEATH 10-24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto City-Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto City 17-02

c. Length of stay in Baltimore All Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 321 Myrtle Ave

5. SEX Fem

6. COLOR OR RACE Col

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 5-24-1894

9. AGE (In years last birthday) 55 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Washington - D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Kellman Jackson

14. MOTHER'S MAIDEN NAME Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) ✓ (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Ethel Williams-Dau ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: not known

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) aortic Insufficiency — not known

DUE TO

(C) aortitis — not known

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertrophic arthritis both Knees — not known

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9.21.1945 19__, *to* 10.24.1949 19__, *that I last saw the deceased alive on* 10.14.49 19__, *and that death occurred at* 4A *m., from the causes and on the date stated above.*

23A. SIGNATURE James M. Pair M.D.

23B. ADDRESS 400 N. Carrollton ave

23C. DATE SIGNED 10.26.49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 10-28-49

24C. NAME OF CEMETERY OR CREMATORY Mt Calvary

24D. LOCATION (City, town, or county) (State) B.A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR OCT 27 1949

REGISTRAR'S SIGNATURE Livingston Williams M.D.

25. FUNERAL DIRECTOR Wm. H. R. Williams ADDRESS 322 N. Schroeder St.

VS 150

92 c

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79294 G79294

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Depsy Lyles.

2. DATE OF DEATH: 10 - 23 - 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 203 N. Fremont Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 203 N. Fremont Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 4-02
D. STREET ADDRESS (If rural, give location): 203 N. Fremont Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | married | march 25, 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Montgomery Co Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel J. Zigler | Lyade |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Rev. Ronnie Lyles. | 203 N. Fremont Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive — 2 mos.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/22 19 49 *to* 10/23 19 49, *that I last saw the deceased alive on* 10/24 19 49 *and that death occurred at* 11 P M *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry L. McKelvane M. D. | 1131 Harlem Ave | 10/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-27-1949 | Friendship | Montgomery Co Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Cunningham Williams, M.D. | Mrs Ketu R Williams | 323 N Schroeder St. |

VS 150

83a

G79295

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 68649 Registered No. 420 · 1

1. NAME OF DECEASED (Type or Print): Lula L. Neuhauser

2. DATE OF DEATH: Oct. 25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 824 S. Rappola St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 1-02
D. STREET ADDRESS (If rural, give location): 613 S. Robinson St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov. 19-1896 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Balto. Md. | |

13. FATHER'S NAME: Albert Edward

14. MOTHER'S MAIDEN NAME: Sarah Fadgan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Thomas J. Neuhauser | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease.

DUE TO

(B) Generalized arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 14, 1949 *to* Oct. 25, 1949, *that I last saw the deceased alive on* Oct 15, 1949, *and that death occurred at* 2:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward A. Flanigan M.D. | 3503 Fait Ave | 10-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Oct. 29/49 | Holy Redeemer Cem | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 29 1949 | Hampton Williams M.D. | John L. Miller | 2334 Jefferson St. |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79296

G79296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD H. KONOW

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2208 Allendale Rd.
c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2208 Allendale Rd. 15-48

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 18, 1873 | 76 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Credit Manager | Shoe Findings | Baltimore, Md. | |

13. FATHER'S NAME: Frederick W. Konow

14. MOTHER'S MAIDEN NAME: Amelia Tribull

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | | | Mr. Edgar Konow | 2313 Rosedale St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lungs — (Interval between onset and death): ?

DUE TO

(B) Broncho pneumonia — (Interval between onset and death): 3 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug 19, 1949, to Oct. 25, 1949, *that I last saw the deceased alive on* Oct 25, 1949 *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter J. Birkhead M. D. | 2220 Garrison Blvd | Oct 26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1949 | Huntington for Williams, M.D. | WM. J. TICKNER & SONS | Baltimore, Md. |

VS 150

47)

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679-57 ✓ 679-57

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 204.1 Registered No.

1. NAME OF DECEASED (Type or Print): IDA HENRIETTA HICKMAN
2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Park Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-01
D. STREET ADDRESS (If rural, give location): 817 St. Paul Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Wid. | 2/22/87 | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Probation Officer | Supreme Court of Balto. | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm. Dankmeyer | Anna Margaret Hinkler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| ? | ? | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Chronic myelogenous leukemia | 2 yrs. |
| | DUE TO (B) | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 21, 1949, *to* Oct. 25, 1949 *that I last saw the deceased alive on* Oct. 25, 1949, *and that death occurred at* 4:25P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto. 11, Md. | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10.28.49 | Druid Ridge Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1949 | [illegible] | W. J. TICKNER & SONS | Balto., Md. |

VS 150

74a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

679-98 ✓ 679-98

BIRTH NO. 679-98

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 45 ✓

Registered No.

1. NAME OF DECEASED (Type or Print): John Williams

2. DATE OF DEATH: 10-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

C. Length of stay in Baltimore: 43 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01
D. STREET ADDRESS (If rural, give location): 1215 N. Fanvale St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | Dec. 7, 1905 | 43 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Auto Repair
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Andrew Williams
14. MOTHER'S MAIDEN NAME: Mary Delia Forbes
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 216-05-0987
17. INFORMANT: Mrs. Rose Hallie ADDRESS 1215 N. Fanvale St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ruptured aneurysm - innominate artery
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 10-24-49
19B. MAJOR FINDINGS OF OPERATION (A) INNOMINATE: Aneurysm - innominate artery
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1, 1949 *to* 10-25, 1949 *that I last saw the deceased alive on* 10-25, 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: University Hosp
23C. DATE SIGNED: 10-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Peters Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 27 1949
REGISTRAR'S SIGNATURE: [signature], M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1621 Druid Hill Ave.

VS 150

96

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79299

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sally Keys

2. DATE OF DEATH: October 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 808 Tyson Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 808 Tyson Street 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widow | March 4, 18 72 | 77 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Easton, Maryland | U.S.A. |

13. FATHER'S NAME: Stephen Sampson

14. MOTHER'S MAIDEN NAME: Lizzie Copper

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs Pauline Keys | 808 Tyson St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1½ Yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-4, 1948 *to* 10-23, 1949 *that I last saw the deceased alive on* 10-23, 1949 *and that death occurred at* 8:30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Atwell Jones M. D. | 3-3-48 Holbrook St | 10-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-27-49 | Mount Zion | Baltimore Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 25 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Holland Funeral Home 1631 Druid Hill Ave.

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679300 ✓ 679300

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 4200

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MELVIEN MAY REIDY

2. DATE OF DEATH: June. Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital 2724 N. Charles St

C. Length of stay in Baltimore: About 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-07
D. STREET ADDRESS (If rural, give location): 1555 Homestead St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Oct. 21, 1876 | 73 | — | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Harford Co, Md. | USA |

13. FATHER'S NAME: (?) Foster

14. MOTHER'S MAIDEN NAME: Barbara Ann (?)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Charles M. Reidy (Son) | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Empyema Gall Bladder.

DUE TO

(C) Chronic Arteriosclerotic Heart Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Diabetes Mellitus. Operation Good Complete

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct 21, 1949 | Patient died at beginning of operation | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. I hereby certify that I attended the deceased from Oct 2, 1949 to Oct 21, 1949; that I last saw the deceased alive on Oct 21, 1949 and that death occurred at 4:40 P.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Peter Tsanoudis M. D. | 5911 Eastern Ave. | Oct 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Fri. Oct. 28, 1949 | Meadow Ridge Cem. | Howard Co, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Registrar for Williams, M.D. | G. Howard Evans | 1400 S. Charles St Balto 30 Md. |

VS 150

1270

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79301 ✓ ✓ G79302

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE W. KAUL
2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2013 McKean Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2013 McKean Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 9, 1869 | 80 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Owner | Delicatessen Store | Balto., Md. | |

13. FATHER'S NAME: George W. Kaul
14. MOTHER'S MAIDEN NAME: Caroline Steeg

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Carrie V. Kaul | 2013 McKean Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 1, 1948 *to* Oct 25 1949, *that I last saw the deceased alive on* Oct 25 1949, *and that death occurred at* 3 PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry C Houck M.D. | 1914 W Mt St Balto | 10/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79302 ✓ G79302

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

454 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY ANNA AMBROSE

2. DATE OF DEATH: 10-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4700 Harford Road

C. Length of stay in Baltimore: Harford Convalescent Home — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-02
D. STREET ADDRESS (If rural, give location): 4700 Harford Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | - | Baltimore, Md. | |

13. FATHER'S NAME: Frederick Rice

14. MOTHER'S MAIDEN NAME: Elizabeth Weidekemper

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | -- | -- | HARFORD CONV HOME | 4700 HARFORD RD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombus Left Fem. Vein — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Myocarditis + Senility — undetermin ate

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 20, 19 49 *to* Oct 25, 19 49, *that I last saw the deceased alive on* Oct 23, 19 49, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. H. Hayward M. D. | 22 E Eager St Balto | Oct 26 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-28-49 | Holy Redeemer Cem. | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Huntington Williams, Asst | WIEDEFELD AND SON | GREENMOUNT AVE. & 22nd ST |

VS 150

93E

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79.03 ✓ G79.03

BIRTH NO. 49-14832

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 19 2 Registered No.

1. NAME OF DECEASED (Type or Print): JAMES HOBAN

2. DATE OF DEATH: October 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2325 Calvert Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 2325 Calvert Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | SINGLE | June 5, 1949 | | 4 | 21 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | W. Virginia | |

13. FATHER'S NAME: Leo Hoban

14. MOTHER'S MAIDEN NAME: Julia Grasino

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Leo Hoban | 2325 N. Calvert St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Miliary tuberculosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L. Rose M.D. | | Oct. 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10-29-49 | Vera Alta | West Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Huntington Williams, M.D. | Needfeld & Sons | 201 E. 22nd St |

VS 151

13B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 Frame

G79:04

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79:04

BIRTH NO. 7270 Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Dean

2. DATE OF DEATH: 10/24/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1144 E. Lombard St.

C. Length of stay in Baltimore: 10 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 3-02
D. STREET ADDRESS (If rural, give location): 1144 E. Lombard St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Single | 11/10/1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Public | Centersville Md. | U.S.A. |

13. FATHER'S NAME: George Wilson

14. MOTHER'S MAIDEN NAME: May Wilson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Hughlett Hammond | 1163 E. Lombard St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Bronchial pneumonia | 10 days. |
| DUE TO | | |
| (B) | malnutrition | 30 days. |
| DUE TO | | |
| (C) | Rheumatoid arthritis | 2 yrs. |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Sept. 1949, *to* 24 October 1949, *that I last saw the deceased alive on* 10-28 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. C. Burwell M. D. | 121 Eisenwood St. | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/1949 | Mt Calvery Cem. | Brooklyn A.A.Co.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Brantly Ave |

VS 150

107

1 E G79305 — E81.0 G79305

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

N 864.0

1. NAME OF DECEASED (Type or Print): HERBERT PRITCHETT
2. DATE OF DEATH: October 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 3-01
D. STREET ADDRESS (If rural, give location): 123 S. Caroline Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Single | Feb. 15. 1941 | 8 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School Child | School | Baltimore City | U.S.A. |

13. FATHER'S NAME: Vance Pritchett
14. MOTHER'S MAIDEN NAME: Clory Belle Penn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Clory B. Penn | 123 S. Caroline St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rupture of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Caroline and Pratt Streets
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: October 24, 1949 2.50 P.M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCoccur? Pedestrian struck by truck — 3/1

22. *I certify that I took charge of the remains described above, held an* ____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L. Rose M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/28/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn A.A.Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brantly Ave

VS 151

170c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79506 G79506

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Etta L. Fraser
2. DATE OF DEATH: Oct. 26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4700 Harford Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harford Convalescent Home
C. Length of stay in Baltimore: 35 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3431 Ravenswood Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-01
D. STREET ADDRESS (If rural, give location) 3431 Ravenswood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | widowed | Jan 14/76 | 73 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | None | Maryland | |

13. FATHER'S NAME: Geo. Jones
14. MOTHER'S MAIDEN NAME: Mary Windsor

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy with right hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 1946

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 3-17- 1949 *to* 4-4- 1949 *that I last saw the deceased alive on* 4-4- 1949, *and that death occurred at* 8 20 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nelson C. Long M. D. | 2117 Belair Rd | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Baltimore | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 27 1949 | Huntington Williams, M.D. | Philip Henrig Sons Orleans St 2024 |

VS 150

832a

Correct age if especially important. Physicians: please write the cause of death clearly and legibly.

679307 BALTIMORE CITY HEALTH DEPARTMENT 420 679307

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MR. UPTON SLINGLUFF BRADY

2. DATE OF DEATH 10/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSP.
c. Length of stay in Baltimore 76 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 14-01
D. STREET ADDRESS (If rural, give location) 1419 BOLTON STREET

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M | AUG 21, 1873 | 76 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired [redacted]. | Eng. & Mach. Co. | BALTIMORE Co., MD. | USA. |

13. FATHER'S NAME MR. SAMUEL BRADY
14. MOTHER'S MAIDEN NAME [redacted] HELEN SLINGLUFF

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes [redacted] Spanish-American | 213-10-3757 | MRS. ANNE BRADY | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAC INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 8 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CORONARY OCCLUSION

DUE TO

(C) ARTERIOSCLEROTIC HEART DISEASE — YRS.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/23 *,* 1949 *, to* 10/26 *,* 1949 *, that I last saw the deceased alive on* 10/26 *,* 1949 *, and that death occurred at* 12:52 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Frank Supplee, Jr. M. D. | Union Memorial Hosp | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 29/49 | Prospect Hill | Towson, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 VS 450 | Huntington for Williams, M.D. | Stewart & Mowen Co. | 108 W. North Ave |

City #1. 93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:08

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450:0 G79:08 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY HELEN FULLWOOD

2. DATE OF DEATH: Oct. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for the Aged of the Methodist Church, 2211 W. Rogers Ave.

C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-15
D. STREET ADDRESS (If rural, give location): 2211 W. Rogers Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | July 31, 1868 | 81 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Baltimore, Md. | |

13. FATHER'S NAME: Charles Hunter Fullwood

14. MOTHER'S MAIDEN NAME: Margaret Jane Creamer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Miss Miriam O. Coates | 2211 W. Rogers Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency — Interval between onset and death: 5 days.

DUE TO

(B) Arteriosclerosis — 20 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 2, 1945 *to* Octobes 26, 1949, *that I last saw the deceased alive on* Oct. 26, 1949, *and that death occurred at* 12 47 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Carlton J. Dawes M. D. | 8002 W 33rd St | 10-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | Greenmount Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 1949 | Hunter for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

93 D

Correct age is especially important. If uncertain, please write the names of birth county and registry.

G79.09

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 no. 1 G79.09

BIRTH NO. Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | HERBERT ANDREW SIMPSON |
| 2. DATE OF DEATH | Oct. 26, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 218 Northway |
| C. Length of stay in Baltimore | life (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 27-11 |
| D. STREET ADDRESS (If rural, give location) | 218 Northway |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Mar. 17, 1884 |
| 9. AGE (In years last birthday) | 65 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.) |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Vice President |
| 10B. KIND OF BUSINESS OR INDUSTRY | Wholesale Paper Business |
| 11. BIRTHPLACE (State or foreign country) | Balto., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Francis Marion Simpson |
| 14. MOTHER'S MAIDEN NAME | Mary Ann MacTaggart |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | Mr. Charles C. Simpson |
| ADDRESS | 218 Northway |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic C-V-D — 2

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| NONE | — | |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| — | — | — |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
| — m. | | — |

22. *I hereby certify that I attended the deceased from* Oct 18, 1949, *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 26, 1949, *and that death occurred at* 3:30 p. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| John M. Scott M. D. | 8 Longwood Road | Oct 27, 1949 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| Burial | 10/28/49 | Loudon Park Cem. | Balto., | Md. |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| OCT 27 1949 | Thurlington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G7931.0 ✓ ✗ 33 ✓ G7931.0

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary W. Rawlings
2. DATE OF DEATH: 10-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rising Sun
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 11-8-94 | 54 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Walter T. Wright
14. MOTHER'S MAIDEN NAME: Mabel E. Glackin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO
17. INFORMANT: Roscoe Rawlings ADDRESS: asabove

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary edema & Cardiac decompensation | 12 ± hrs |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (B) Cerebral Thrombosis ? | 12 hrs |
| DUE TO and | (C) Pneumonitis | 3-4 wks |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Anemia Splenomegaly Residual hemiplegia Weak left hemiplegia | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24 19 49 *to* 10-28 19 49 *that I last saw the deceased alive on* 10-28 19 49 *and that death occurred at* 1 10 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Vivian Candler M.D.
23B. ADDRESS: Maryland General Hosp.
23C. DATE SIGNED: 10-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 31 1949
24C. NAME OF CEMETERY OR CREMATORY: Hopewell
24D. LOCATION (City, town, or county) (State): Deposit Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: [illegible] ADDRESS: Rising Sun Md

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

R3B

G79311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79.11

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH RYAN GILLIAM

2. DATE OF DEATH: Oct. 27. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 912 E. Preston St.
c. Length of stay in Baltimore: 64 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 912 E. Preston St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Mar. 25, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk retired | U.S. Postal Service | Edenton, N.C. | |

13. FATHER'S NAME: Edward W. Gilliam

14. MOTHER'S MAIDEN NAME: Emily T. Ryan

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | None | Mrs Rosa Gilliam, 912 E. Preston St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 3 days |
| DUE TO (B) | Cardio-Vascular-Renal Disease ? | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug 11, 1946 *to* 27 Oct, 1949, *that I last saw the deceased alive on* 26 Oct, 1949, *and that death occurred at* 2:45 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. Lilienfeld M.D. | 714 E. Preston St. | 27 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | Druid Ridge | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

131a

679.1.12 679.1.12

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MA RY JOHANNA DAVIS
2. DATE OF DEATH: Oct. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3339 Elmora Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 3339 Elmora Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Nov. 5, 1872 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Charwoman, retired | The Canton Co | New Jersey | |

13. FATHER'S NAME: John Weisenborne
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Edwin J. Cross | 2512 E. Eager St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Renal Vascular disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Uremia
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs +; 3 days -

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 1, 1949, *to* October 27, 1949 *that I last saw the deceased alive on* 10-26, 1949, *and that death occurred at* 3:45 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Schneider M.D. | 1101 N. Milton Ave | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

1312

G79-453 G79-453

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) LESLIE B. RIGGS

2. DATE OF DEATH 10/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO. GEN. HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 24-01
D. STREET ADDRESS (If rural, give location) 1314 E. FORT AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE (MARRIED) WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Jan. 3rd 1915 | 34 | 9 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steam Fireman | Bethlehem Steel | Balto. Md. | |

13. FATHER'S NAME Frank Riggs

14. MOTHER'S MAIDEN NAME Emma Davis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 217-14-0785 | Marie T. Riggs | 1314 E. Fort Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL HEMORRHAGE — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CARDIOVASCULAR DISEASE — DUE TO

(C) — DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/25 1949, *to* 10/26, 1949 *that I last saw the deceased alive on* 10/26, 1949, *and that death occurred at* 9:35 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William B. Cooper M. D. | South Balto. Gen. Hosp. | 10/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | U. S. National | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 1217 St. Paul St. |

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

937

079314 CERTIFICATE CORRECTED 10-28-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Ptr. 1 079314 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas A. Gilliam

2. DATE OF DEATH: 10/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1530 Bolton Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 6/1/1870 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Edward Gilliam (dec'd)
14. MOTHER'S MAIDEN NAME: Emily Turner (dec'd)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: David Gilliam ADDRESS: 1530 Bolton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congestive failure
DUE TO
(B) Arteriosclerotic CVD
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/17 19 49 *to* 10/25, 19 49 *that I last saw the deceased alive on* 10/25 19 49, *and that death occurred at* 6 25 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Hubert J. Sinclair M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 10/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/28/49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24D. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

927

G79.15 ✓ G79.15

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET H. NAGLE

2. DATE OF DEATH: Oct 26 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 3024 Guilford Av

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ~

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12-02
D. STREET ADDRESS (If rural, give location): 3024 Guilford Av

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | FEB 15 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | ~ | MARYLAND | USA |

13. FATHER'S NAME: JACOB HESS

14. MOTHER'S MAIDEN NAME: MARY PRESTON

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | ~ | Carl Nagle | 3024 Guilford |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovas. Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yr
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 15 1949 *to* Oct 26, 1949 *that I last saw the deceased alive on* Oct 26, 1949 *and that death occurred at* 7:12 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fritz J Kinzer M.D. | 2700 Harford Rd | Oct 27 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 10/28/49 | GOODWILL CEMETERY | RUTLEDGE, MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | JOHN F. DENNY, Inc. | 715 Light St-30 |

VS 150

93D

679.16 ✓ 679.16

MS—132866 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

490 6 Registered No.

1. NAME OF DECEASED (Type or Print): William Beal

2. DATE OF DEATH: 10-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-03
D. STREET ADDRESS (If rural, give location): 203 E. Hamburg St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 3/25/1890
9. AGE (In years last birthday): 59 ? (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10B. KIND OF BUSINESS OR INDUSTRY: SHIPYARD
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Beal
14. MOTHER'S MAIDEN NAME: Martha ? BEALL ✓
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: ADDRESS: Baltimore City Hospitals Records— 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24- , 1949, *to* 10-26- , 1949, *that I last saw the deceased alive on* 10-26-49, *and that death occurred at* 8:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 10-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL.
24B. DATE: 10/29/49
24C. NAME OF CEMETERY OR CREMATORY: CEDAR HILL
24D. LOCATION (City, town, or county) (State): RITCHIE HIGHWAY, MD.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: ADDRESS: JOHN F. DENNY, INC 7154 GAT ST-30

VS 150

108

679.17 No. 1 679.17

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Joseph A. Foey

2. DATE OF DEATH: 10-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 910 St. Paul St.

C. Length of stay in Baltimore: 50 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 910 St. Paul St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | Aug. 9, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Latrobe Apt. Hotel | Freehold, N. J. | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | 212-03-3092 | Rose Nell Haight | 910 St. Paul St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 2 hours |
| DUE TO | Generalized arteriosclerosis & aortic stenosis & insufficiency | many years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug, 1946 *to* 27 Oct, 1949 *that I last saw the deceased alive on* 27 Oct, 1949, *and that death occurred at* 8:30 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. E. Wice, M. D. | 920 St Paul St. | 27 Oct. '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | St. Rose of Lima | Freehold, N. J. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Chas. A. Cole | 1913 W. Baltimore St. |

VS 150

92a

G79-18 ✓ 450.0 G79-18

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Hughes
2. DATE OF DEATH: Oct. 25, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 114 W. Montgomery St.
5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1859
9. AGE (In years last birthday): 90 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Matthews Co., Va
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Sallie Ana Foster
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Lewis Cornell-114 W. Montgomery St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteri-Sclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒ (Surg)
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Earl L. Royster M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Oct. 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/29/49
24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn Ct.
24D. LOCATION (City, town, or county) (State): Baltimore, City.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. L. Brown ADDRESS: 108 W. Montgomery St

VS 151

97

G79.19 ✓ 900.0 G79.19

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. E

1. NAME OF DECEASED (Type or Print): John Edward Grimes — N-807.0
2. DATE OF DEATH: Oct. 26, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-07
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 3624 Malden Avenue
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: April 9, 1872
9. AGE (In years last birthday): 77 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — carpenter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Henry Grimes
14. MOTHER'S MAIDEN NAME: Annie Gray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: Union Memorial Hospital records

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage, generalized — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Injury (fall) — 8 hrs.
DUE TO

CERTIFICATION APPROVED BY For Dr. Wm. Helfrich R.S. Forbes M.D. CHIEF OR ASST. MEDICAL EXAMINER

(C) Hypertensive cardiovascular disease — 2+ years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Ruptured Spleen, Multiple fractures of ribs & left clavicle — 18 hrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident (Fall)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): dwelling house
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3619 Malden Avenue 13/8
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 25, 1949 3 P.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Pt. fell backward down stairs

22. *I hereby certify that I attended the deceased from* Oct 25, 1949, *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 26, 1949, *and that death occurred at* 9:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William A. Ranson M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: Oct 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Oct 29 1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Austin E. Donovan 3818 Roland Ave

VS 150

186a

679.520 BALTIMORE CITY HEALTH DEPARTMENT 679.520

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. E81 7.4

1. NAME OF DECEASED (Type or Print): Richard Williams N-804 7
2. DATE OF DEATH: Oct. 23, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
c. Length of stay in Baltimore: 4 Years
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-61; D. STREET ADDRESS (If rural, give location): 425 N. Spring St.
5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Feb. 20 1914
9. AGE (In years last birthday): 35 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bainbridge Georgia
12. CITIZEN OF WHAT COUNTRY? Yes
13. FATHER'S NAME: George Williams
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): 2nd World War
16. SOCIAL SECURITY NO: NO-259-12-5026
17. INFORMANT: Fannie Williams ADDRESS: 425-N-Spring St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture, skull

DUE TO Sub-arachnoid Hemorrhage.

(B) Fracture - dislocation Vertebra L,

DUE TO Compound fracture, right leg

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Pennington & Alder St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 23, 1949 1 A m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 2515

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct-28-49
24C. NAME OF CEMETERY OR CREMATORY: White Bridge
24D. LOCATION (City, town, or county) (State): Bainbridge Ga.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 Hunt Hill Ave 1700

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79.21 ✓ 54.4 G79.21

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-28880 Registered No.

1. NAME OF DECEASED (Type or Print): BABY GIRL HORELICK

2. DATE OF DEATH: Oct. 23, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSP.

C. Length of stay in Baltimore: Yrs. / Mos. 1 / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Franklin Square Hospital
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 15-07
D. STREET ADDRESS (If rural, give location): 3727 Nortonia Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| GIRL | WHITE | SINGLE | Oct. 22, 1949 | | | 32 / 18 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NEWBORN
10B. KIND OF BUSINESS OR INDUSTRY: NEWBORN.
11. BIRTHPLACE (State or foreign country): Franklin Square
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: JULES HORELICK
14. MOTHER'S MAIDEN NAME: EVE LIEBMAN.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mother ADDRESS: 3727 Nortonia Road.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Congenital Heart Disease | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Adrenal Hemorrhage. | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 22 1949 *to* Oct. 23, 1949 *that I last saw the deceased alive on* Oct. 23, 1949, *and that death occurred at* 11 20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Amsterdam M. D.
23B. ADDRESS: Franklin Sq. Hospital
23C. DATE SIGNED: Oct 25

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL OCT 26 1949

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS
COMMISSIONER of Health

VS 150

157E

G79.22

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 776

G79.22

BIRTH NO. 49-23175 Registered No.

1. NAME OF DECEASED (Type or Print) Pinkney Baby Boy

2. DATE OF DEATH 10-24-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital
c. Length of stay in Baltimore 1 hr 29 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21-01
D. STREET ADDRESS (If rural, give location) 212 S. Fremont Ave. # 3.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | S | 10-23-49 | | | 1 29 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Md | U.S. |

13. FATHER'S NAME Howard Daniel Pinkney

14. MOTHER'S MAIDEN NAME Marie Simms.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mother | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Premature baby.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-23 *1949 to* 10-24 *, 1949, that I last saw the deceased alive on* 10-24 *, 1949, and that death occurred at* 1:45 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. W. Talley M. D. | University Hospital Balto Md | 10/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL OCT 26 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

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G79323 BALTIMORE CITY HEALTH DEPARTMENT G79323

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MAX SCHUDEL

2. DATE OF DEATH: Oct. 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pine Ridge Nursing Home

c. Length of stay in Baltimore: 65 yrs (Yrs. / Mos. / Dys.)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-03

D. STREET ADDRESS (If rural, give location): 4803 Morello Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | W | widower | Dec. 1, 1864 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cabinet Maker | Retired - 7 yrs | Switzerland | USA |

13. FATHER'S NAME: John J. Schudel

14. MOTHER'S MAIDEN NAME: Anna Wanner

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Name and Address) |
|---|---|---|
| no | none | 4803 Morello Road - 14 Mrs. Wm. Nolte |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Prostate — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1948 | Carcinoma Prostate | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* Oct 26, 1949 *that I last saw the deceased alive on* Oct 26 1949 *and that death occurred at* 1:35 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Ernest Walter M.D. | 319 Md Ave Balto | 10/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 10/28/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. |

VS 150

51B

G79324 132354

BALTIMORE CITY HEALTH DEPARTMENT 171 G79324

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Koritzka

2. DATE OF DEATH: 10- 25- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-01
D. STREET ADDRESS (If rural, give location): 1115 Haubert St. Z 30

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 13-1916 | 33 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MD. | |

13. FATHER'S NAME: Stine Walizak ( D )

14. MOTHER'S MAIDEN NAME: Mary Taylor

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | B.C.H. Records 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Generalized Carcinomatosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Carcinoma of the Cercix | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pulmonary Tuberculosis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-4- , 1949 *to* 10- 25- , 1949 *that I last saw the deceased alive on* 10-25- 1949 *, and that death occurred at* 1.50 PM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | B.C.H. 4940 Eastern Ave. | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-29-49 | Holy Cross Cem. | Annapolis Blvd. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | [illegible] | Chas. F Dill | 1501 E. Fort Ave |

VS 150

48a

G79325

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G79325

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARYANNA OTREMBA

2. DATE OF DEATH: October 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1709 Lancaster Street

c. Length of stay in Baltimore: 73 (Yrs. / Mos. / Dys)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-03
D. STREET ADDRESS (If rural, give location): 1709 Lancaster Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | May 10, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | --- | Poland | USA |

13. FATHER'S NAME: -------- Urban

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| --- | --- | Mrs. Veronica Krysiak | 1709 Lancaster St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive Cardio-Vascular Disease | |
| | DUE TO (B) | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 12, 1949, *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 25, 1949 *and that death occurred at* 8:45 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2579 Eastern Av. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | St. Stanislaus | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 27 | Huntington Williams M.D. | M. F. Sadowski & Sons | 1808 Eastern Avenue |

VS 150

93D

BIRTH NO. 79326

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G79326

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | Bessie | Ashton | 2. DATE OF DEATH Oct. 28, 1949 |

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE W. Virginia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Martinsburg
D. STREET ADDRESS (If rural, give location) 116 Swartz St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | married | Sept. 21, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | West Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James E. Elliott | Florence Hoffman |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | George R. Ashton | 116 Schwartz St. W.Va. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-vascular disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. + Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| H. L. McClafferty M.D. | | Oct. 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| removal | 10-28-49 | Rosedale | Martinsburg, W. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams, M.D. | Jos. J. Tichnor & Sons | Balto 47 Md |

VS 151

937

G79327 ✓ G79327

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

51 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry A. Eck

2. DATE OF DEATH: Oct 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 222 E University Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | May 22, 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: August Eck
14. MOTHER'S MAIDEN NAME: Catherine Fischer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis — (INTERVAL BETWEEN ONSET AND DEATH) Weeks
DUE TO
(B) Carcinoma of the pancreas — Many Years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 8, 1949, *to* Oct 27, 1949, *that I last saw the deceased alive on* Oct 27, 1949, *and that death occurred at* 7 15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. F. Coe 3rd M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 10-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Oct 31-1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellsworth Armacost
ADDRESS: 5118 Sturgis Oak Ave 46g

VS 150

G79328 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

61 Registered No. G79328

1. NAME OF DECEASED (Type or Print): George Sibiski (Sibiski) — 2. DATE OF DEATH: 10/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3030 Elliott St 1-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | 12/24/1874 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | | Md. | U.S.A. |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | ? | Marie Sibiski | 3030 Elliott St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Kidney — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) ..... DUE TO
(C) .....

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| C. E. Schmidt M.D. | ☐ ☐ ☑ | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/ /49 | St. Stanislaus | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS: Lilly & Zeiler Inc. Balto. Md.

VS 151

47a

Correct age is frequently important. Physicians: please write the causes of death clearly and legibly.

G79329 G79329

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 41

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Catherine E Allen

2. DATE OF DEATH 10-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1907 Griffis Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Balto Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1907 Griffis Ave
D. STREET ADDRESS (If rural, give location) 25-43

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | June 11-1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John J Mony
14. MOTHER'S MAIDEN NAME Anna M Zajac
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Catherine A. Allen ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Uremia | 3 wks |
| DUE TO | | |
| (B) | Hypertensive Cardiorenal Disease | 3 wks |
| DUE TO | | |
| (C) | Malignant Hypertension | 2½ yrs. |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 26, 1948 *to* Oct. 25, 1949, *that I last saw the deceased alive on* Oct. 25, 1949, *and that death occurred at* 9 30 *m., from the causes and on the date stated above.*

23A. SIGNATURE C. Wilbur Rosebery M.D.
23B. ADDRESS 2411 Wash. Blvd.
23C. DATE SIGNED 10/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 10-29-49
24C. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem
24D. LOCATION (City, town, or county) (State) Wash Blvd

DATE RECEIVED BY LOCAL REGISTRAR OCT 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Edward Jonson ADDRESS 2359 Wash Blvd Balto Md

VS 150

121a

G79330

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79330 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Etta Lingan

2. DATE OF DEATH: Oct 26 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 25-43

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1702 Sexton st

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1702 Sexton st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | married | July 6 884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home | Home | Balto Md | USA |

13. FATHER'S NAME: William Grace

14. MOTHER'S MAIDEN NAME: Henrietta Whitehead

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | No | William Lingan | Balto Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Metastases — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Cardio Vascular Disease — 1 yr

DUE TO

(C) Carcinoma Breast — yrs

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Jan 49 | Amputation right Breast Carcinoma | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 4 49 *to* Oct 26 1949 *that I last saw the deceased alive on* Oct 25 1949 *and that death occurred at* 5-15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. McKiffen M.D. | 1470 Park Blvd | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-29-49 | Loudon Park | Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Registrar of Vital Statistics, Md | Edward Loudon | 2369 Park Blvd Balto Md |

VS 150

50

CERTIFICATE CORRECTED 11-9-49

G79331

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

(Arkadija Mrvicin)

G79331

Registered No. 1949

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alexander Mrvicin

2. DATE OF DEATH: Oct 27 1949 — 1:30 PM

3. PLACE OF DEATH:
A. Baltimore City, Maryland 325 S. Woodyear St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 35 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto
B. COUNTY: Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 325 S woodyear St
D. STREET ADDRESS (If rural, give location): 19-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | August 22, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stone Cutter | Stone | | U-S |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrvicin — ADDRESS: 325 S woodyear

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Renal

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: William G Helfrich M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 10-27-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 31. 1949 | Loudon Park | 3801 Fredrick Ave Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949

REGISTRAR'S SIGNATURE: Washington for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Robt G. & B. Jr. Walters 1213 S. Stricker

VS 151

937 ✓ SC

G79332

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

491

G79332

BIRTH NO. 49-17307 Registered No.

1. NAME OF DECEASED (Type or Print): Robert Peay Jr.

2. DATE OF DEATH: 10-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1019 Warner St
C. Length of stay in Baltimore: 1 Yrs. 2 Mos. 19 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-01
D. STREET ADDRESS (If rural, give location): 1019 Warner St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | Single | 8-6-48 | 1 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Robert Peay
14. MOTHER'S MAIDEN NAME: Mary C. Ruby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Robert Peay ADDRESS: 1019 Warner St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 23 19 49 *to* Oct 25 19 49 *that I last saw the deceased alive on* Oct 25 19 49 *and that death occurred at* 4.35 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John W. Gaines M. D. | 507 W. Hamburg St | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/28/49 | Mt Auburn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Temporary for Williams, M.D. | Charles A. Rice | 664 W Baltimore St |

VS 150

107

G79533

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79533 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WELLIE PRACHT SMITH

2. DATE OF DEATH: 26 OCT. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: UNK. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: DELAWARE
B COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MILFORD
D. STREET ADDRESS (If rural, give location): — 312 S. Washington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | JULY 3, 1863 | 86 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | BALTIMORE, MD. | USA |

13. FATHER'S NAME: AUGUSTUS PRACHT

14. MOTHER'S MAIDEN NAME: WELLS ETTA COOPER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| NO | no | MRS. FREDERICK TORSCH | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: YRS.

DUE TO

(B) ARTERIOSCLEROTIC HEART DISEASE

DUE TO

(C) Calcific aortic stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

UREMIA, HEMORRHAGE FROM BOWEL

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 5 OCTOBER, 1949, *to* 26 OCTOBER, 1949, *that I last saw the deceased alive on* 26 OCTOBER, 1949, *and that death occurred at* 11:25 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Charles H. Watt, Jr., M. D. | Union Memorial Hospital | 10/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | Green Mount Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92a

G79334

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

19 49-6

G79334

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Demski

2. DATE OF DEATH: Oct. 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1631 Gough St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 1631 Gough St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Unknown | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Trucking | Business | Poland | |

13. FATHER'S NAME: Jacob Demski

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Demski ADDRESS 1631 Gough St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) adenocarcinoma of pelvis lumbar spine Bone.
DUE TO and right femur.
(Primary site unknown)
(B) Generalized bronchopneumonia
DUE TO Contributory

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1949 *to* Oct 29, 1949 *that I last saw the deceased alive on* Oct 31, 1949 *and that death occurred at* 5-45 *A.M., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. L. Lipsey M. D. | 432 N. Patterson Park Ave 31 | 10/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 31/49 | Holy Cross | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Fred W. Ozarzewski | 1930 E. Eastern Ave. 55E |

VS 150

G79335

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Yr. 1

G79335 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice M. Metcalfe

2. DATE OF DEATH: October 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5304 Wayne Ave.

C. Length of stay in Baltimore: 85 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-02
D. STREET ADDRESS (If rural, give location): 5304 Wayne Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Feb. 28, 1854 | 95 yrs | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fredericksburg, Va.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William H. Berry

14. MOTHER'S MAIDEN NAME: Isabelle Rae

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Elmer Hatter, 5304 Wayne Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infirmities of Age — INFIRMITIES

DUE TO

(B) Arteriosclerotic Cardio Vascular Disease VASCULAR

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1949 *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 27, 1949, *and that death occurred at* 1.20P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr Thos J Abbott M. D.

23B. ADDRESS: 4509 Liberty Heights Ave.

23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 29, 1949

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Miller & Moorefield

ADDRESS: 4510 Liberty Heights Ave.

VS 150

93D

G79336 — BALTIMORE CITY HEALTH DEPARTMENT — G79536

BIRTH NO. G79336

# CERTIFICATE OF DEATH

Registered No. 340.0

1. NAME OF DECEASED (Type or Print): DANIEL HOWARD

2. DATE OF DEATH: October 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 601 Pitcher Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | — | 8/8/48 | | 14 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: David G. Howard
14. MOTHER'S MAIDEN NAME: Addie —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: David A. Howard ADDRESS: 601 Pitcher St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia and Meningitis — INTERVAL BETWEEN ONSET AND DEATH: ? 4 hrs

DUE TO Hemophilus influenzae.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/29/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Tunstall Williams, M.D.
25. FUNERAL DIRECTOR: Geo. H. Kelson ADDRESS: 1303 Pennsylvania Ave.

VS

33B

G79337

BIRTH NO. G79337

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 6 v6

1. NAME OF DECEASED (Type or Print): Rhadonia Gaines

2. DATE OF DEATH: OCT 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: 13 Yrs. Mons. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 73-03
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2621 Francis St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | 3-15-11 | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | | Ga. | |

13. FATHER'S NAME: Ernest Teasley

14. MOTHER'S MAIDEN NAME: Ellen Hill

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Pulmonary Emboli — (INTERVAL BETWEEN ONSET AND DEATH) 3 weeks
DUE TO
(B) Pelvic Thrombophlebitis
DUE TO
(C) Tuboovarian Abscesses

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct 12, 1949 | Pelvic abscess | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-10- 1949 *to* 10-27 1949, *that I last saw the deceased alive on* 10-27 1949, *and that death occurred at* 1:25 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Angell M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/30/49 | Elberton, Ga. | Ga. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Wes. H. Nelson | 1303 Pressman |

VS 150

139a

G79338

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79338

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Agnes Marie Dunn

2. DATE OF DEATH: 10-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 54 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 2329 Barclay St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W | Single | Sept. 1, 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School Teacher Retired | School teacher | Maryland | U.S.A |

13. FATHER'S NAME: Harry S. Dunn

14. MOTHER'S MAIDEN NAME: Mary Daley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Thos. E. Coulter | 1214 Harewood Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 22, 1949, *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct. 26, 1949, *and that death occurred at* 11:50 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clifford T. Ratchford Jr. M. D. | Mercy Hospital | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | New Cathedral | [illegible], Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | [illegible] for Williams, M.D. | K. W. Keator and Son | 2 S. Calhoun St. |

OCT 28 1949

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G79339 BALTIMORE CITY HEALTH DEPARTMENT G79339

# CERTIFICATE OF DEATH

Registered No. 17°

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie E Edwards

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 643 Vine St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 643 Vine St.

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1893
9. AGE (In years last birthday): 56 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles Sherwood — ADDRESS: 643 Vine St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinomatosis | unknown |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Cancer of breast metastasis | unknown |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertensive cardiovascular disease | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1949, to Oct 25, 1949, *that I last saw the deceased alive on* Oct 24, 1949, *and that death occurred at* 4²⁰ p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Garland Shirell M. D.
23B. ADDRESS: 902 W. Franklin
23C. DATE SIGNED: 10-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Bur
24B. DATE: 10/31
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Tolstead — ADDRESS: 918 Druid Hill Ave

VS 150

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G79340 ✓ G79340

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-10565 — 49 — Registered No.

1. NAME OF DECEASED (Type or Print): Joyce Yvonne Harold
2. DATE OF DEATH: Oct. 26, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 928. N. Eutaw St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
D STREET ADDRESS (If rural, give location): 928. N. Eutaw St.
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Baby
8. DATE OF BIRTH: June 6, 1949
9. AGE (In years last birthday) / If under 1 Year: Months 4, Days 20 / If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Harold
14. MOTHER'S MAIDEN NAME: Rosalie Joyner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rosalie Harold ADDRESS: 928. N. Eutaw St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia (Broncho) — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diarhea — 10 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 24, 1949 *to* Oct 26, 1949, *that I last saw the deceased alive on* Oct 26, 1949, *and that death occurred at* 6:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. Harland Shirell M. D.
23B. ADDRESS: 902 W. Franklin
23C. DATE SIGNED: 10. 28. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Bur
24B. DATE: Oct 31
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead
ADDRESS: 918 Druid Hill Ave

VS 150

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416 G79341

MS G79341 BALTIMORE CITY HEALTH DEPARTMENT Registered No.

BIRTH NO.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): Sylvia Williams

2. DATE OF DEATH: 10-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1605 Barnes St.
c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-04
D. STREET ADDRESS (If rural, give location): 1605 Barnes St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | 5-5-41 | 8 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: Azariah

14. MOTHER'S MAIDEN NAME: Agnes Williams

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | B.C.H. Records | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Rheumatic Heart Disease with mitral insufficiency and mitral stenosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(b)

DUE TO

(c)

CERTIFICATION APPROVED BY
R. H. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

(over)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-5- , 1947, *to* 10-26- , 1949 *that I last saw the deceased alive on* 10-8- , 1949 *and that death occurred at* 12:15 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. H. Fisher M. D. | 4940 Eastern Ave. | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-28-49 | Mt. Calvary Cem. | Brooklyn A. A. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams M.D. | Elroy O. Wilson | 1000 Brantley ave. |

OCT 28 1949 TO BE APPROVED BY CHIEF MEDICAL EXAMINER

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G79342

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79342 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN A. NORTHWOOD

2. DATE OF DEATH: OCT. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2605 HILLSDALE RD.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): DUNDALK.
D. STREET ADDRESS (If rural, give location): 6911 DUNMANWAY

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | WIDOWED | April 18, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SUPT. OF PERSONELL (R) | BETH STEEL CO. | FRANKLIN, N.J. | U.S |

13. FATHER'S NAME: ALBERT NORTHWOOD

14. MOTHER'S MAIDEN NAME: CAROLINE BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: John A. Northwood Jr. ADDRESS: 891 E. Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage (Rt) — INTERVAL BETWEEN ONSET AND DEATH: 60 days
DUE TO
(B) Arteria Sclerosis —
DUE TO
(C) Lobar Pneumonia Rt-Side — 5 days

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 26, 1949, *to* Oct 27, 1949, *that I last saw the deceased alive on* Oct 27 - 1949, *and that death occurred at* 9 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard H. Warner M. D. | 2604 Garrison Blvd | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Oct. 31, 1949 | GRANDVIEW CEM. | JOHNSTOWN, PA. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949

REGISTRAR'S SIGNATURE: Tuttington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: ROLAND L. FISHER - DUNDALK, MD.

VS 150

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G79343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 yr. 0 G79343

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print) TENNYSON FOX

2. DATE OF DEATH October 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Baltimore General Hospital

c. Length of stay in Baltimore 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-06
D. STREET ADDRESS (If rural, give location) UNKNOWN

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | SINGLE | June 3-1904 | 45 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| GARDNER | LAWNS | Mc Donogh Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| GEORGE W. FOX | SUSAN E. SENTS |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT. ADDRESS |
|---|---|---|---|
| no | no | | Laura Uhler 12 Hawthorne Rd Pikesville 8, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute alcoholism
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | 10/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/29/49 | STONE CHAPEL | PIKESVILLE, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 28 1949 | Emma Lee for Williams, M.D. | Frank H. Newell Pikesville Md. |

VS 151

77c

G79344

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79344

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Lucy Gibbs Kane

2. DATE OF DEATH: Oct. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-03
D. STREET ADDRESS (If rural, give location): 1409 Lemon St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | 12-25-1875 | 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Annie Phillips
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Mackey ADDRESS: 1409 Lemon St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-sclerotic Heart Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Oct. 26, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 10-31-49 | W.P. Calvary Cem. | Cedar Hill | Md. |

DATE RECEIVED BY LOCAL REGISTRAR: 28 1949
REGISTRAR'S SIGNATURE: [signature] Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie R. Williams ADDRESS: 902 N. Schroeder St.

937

VS 151

Dr. Sawyer G79345

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79345

1. NAME OF DECEASED (Type or Print): Frederick N. Leinbach | 2. DATE OF DEATH: 10/27/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2809 Southern Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-02
D. STREET ADDRESS (If rural, give location): 2809 Southern Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | widowed | Mar. 29-1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work, even if working most of working life even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Tailor | | Baltimore, Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Leinbach | Susanna |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Clement Leinbach | 2809 Southern |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchio-pneumonia | 6 days |
| DUE TO | arteriosclerotic Heart Disease | 5 yrs. |
| (B) | | |
| DUE TO | | |
| (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic nephritis | 5 yrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 21, 1949, *to* Oct 27, 1949, *that I last saw the deceased alive on* Oct 27, 1949, *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George Sawyer M. D. | 4808 Harford Rd. | 10/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Parkwood | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Kensington Williams, M.D. | Leonard J. Luck | 5305 Harford Rd. |

VS-196

1318

AB-82790 G79346

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 491

G79346 Registered No.

1. NAME OF DECEASED (Type or Print): John Peters

2. DATE OF DEATH: 10-27-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-01
D. STREET ADDRESS (If rural, give location): 125 Burkett St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Single | March 3- 1888 | 61 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: City Baltimore
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John H. Peters
14. MOTHER'S MAIDEN NAME: Ella K. Buck
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral Thrombosis Due to Arteriosclerosis Old Hemiplezia, Right Side.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-22- , 1943 *to* 10-27- , 1949, *that I last saw the deceased alive on* 10-27- , 1949, *and that death occurred at* 10.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. K. Hogan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 10/31/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
[illegible] SIGNATURE: [illegible], M.D.
25. FUNERAL DIRECTOR: Leonard J. Tuck
ADDRESS: 5305 Harford Rd

83B

G79347 ✓ 43 G79347

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isabelle V. Cuff

2. DATE OF DEATH: 10/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jenkins Memorial Hospital
c. Length of stay in Baltimore: ? Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 9-01
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Baltimore 18
D. STREET ADDRESS (If rural, give location): 723 East 41st Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | widowed | 2/22/1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | — | West Virginia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Bailey Brandenburg | Ida Brandenburg |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | Mrs H. E Nash | 616 Bartlett St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Recurrent Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerotic Hypertensive CVD ? yrs.
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Rheumatoid arthritis & old cerebral hemorrhage c left hemiplegia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from August 31, 1948 to October 27, 1949 that I last saw the deceased alive on Oct. 27, 1949, and that death occurred at 3:45 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert J. Bricker M. D. | St. Agnes Hospital | 10/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-31-49 | New Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Emerson Williams M.D. | John A. Moran | 3000 E Baltimore St. |

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93c

GN 132896
G79348

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 83.0 G79348

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Fowlkes

2. DATE OF DEATH: 10- 25- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 24 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 1413 Madison Ave. Z 17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Sep. | Feb. 28 1896 | 53Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | VA. | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Records B.C.H. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Epistaxis
DUE TO
(B) Uremia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10- 25- , 1949, to 10- 25- , 1949, *that I last saw the deceased alive on* 10- 25- 1949, *and that death occurred at* 1.20 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. S. Cazer | B.C.H. 4940 Eastern Ave. | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 29/49 | Arbutus Mem. Park | Arbutus Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 28 1949 | Interim for Williams, M.D. | Mrs. Robert A. Ellis & Son |

To Be Approved by the Chief Medical Examiner. 11297 M. Cawlins
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G79349

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79349

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clarence Pack — 764.0

2. DATE OF DEATH: OCT 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: A A Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Severna Park
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | single | Sept 10 1949 | | 1 | 18 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Clarence J Pack

14. MOTHER'S MAIDEN NAME: Ferris Davis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic diarrhea

DUE TO Abdominal wall and femoral abscesses.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10·14, 1949 *to* 10·28, 1949, *that I last saw the deceased alive on* 10·28, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W. Mavis M. D. | JOHNS HOPKINS HOSPITAL | 10-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 30 1949 | Townneck Cem. | Severna Park, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 29 1949 | Huntington Williams, M.D. | J. B. Johnson | Annapolis |

119a

G79350

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17°

G79350

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AGNES KIRWAN

2. DATE OF DEATH: 26 Oct 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 224 N. Payson
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 224 N. Payson St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1-10-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housekeeper | — | Maryland | |

13. FATHER'S NAME: Peary E. Appleby

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | — |

17. INFORMANT: Richard L. Suter — ADDRESS: 224 N. Payson St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Breast with metastasis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 Oct 1949 *to* 26 Oct 1949, *that I last saw the deceased alive on* 25 Oct 1949, *and that death occurred at* 2 39 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil W. Henning Jr. M.D. | 4080 Edmondson Ave | 26 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-29-49 | London Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 29 1949 | Huntington Williams, M.D. | George A. Farley, Jr. | Fulton Ave & Fayette St. |

VS 150

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G79351

BALTIMORE CITY HEALTH DEPARTMENT 43 G79351

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CATHERINE E. CUTCHER
2. DATE OF DEATH: 10-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Colonial Nursing Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 20-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3676 Old Frederick Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | ? 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | — | Maryland | |

13. FATHER'S NAME: John Buckhister
14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Charles L. Kennedy | Hamlet N.C. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypertensive Cardiovascular Renal disease | years. |
| DUE TO (B) | Myocardial Failure | 3 days. |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1949 *to* Oct 27, 1949, *that I last saw the deceased alive on* Oct 26, 1949, *and that death occurred at* 11:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wilbur L. Dennis M. D. | 3025 Belair Road | 10-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-29-49 | London Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | George A. Farley, | Fulton and Fayette St. |

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G79352

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450.0

G79352

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): SIDNEY MONTAGUE

2. DATE OF DEATH: October 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New Jersey
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): Oakland Farms

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pimlico Race Track

c. Length of stay in Baltimore: 7 days (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | | | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Royal Roberts | 4813 Laurel ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L Kaye M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Oct. 26, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Shipped | 10/28/49 | Asbury Park | New Jersey |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Rayner Sanders | 97 1412 E. Preston St |

G79353

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 Registered No. G79353

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Allen

2. DATE OF DEATH: October 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 7 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01
D. STREET ADDRESS (If rural, give location): 1205 E. Monument St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 12-1905 | 43 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bundler | | N.C. | |

13. FATHER'S NAME: Frank Allen

14. MOTHER'S MAIDEN NAME: Annie Lindsey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebrovascular Accident | 3 wks. |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertension DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-4, 1949, *to* 10-25, 1949, *that I last saw the deceased alive on* 10-25, 1949, *and that death occurred at* 9:15 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip J. Hagen M. D. | JOHNS HOPKINS HOSPITAL | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Shuard | 10-28-49 | Henderson | N. C. N. C |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 28 1949 | Huntington Williams, M.D. | Rayner Sanders | 1412 E Preston St 23a |

G79354 ✓ G79354

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 5 6 Registered No.

1. NAME OF DECEASED (Type or Print): William Bohiman

2. DATE OF DEATH: Oct. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 59 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: 25-41
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3609 Hinckline Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | June 8, 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Office Worker | Gas + Elect. | Balto. Md. | U.S |

13. FATHER'S NAME: William M. Bohiman

14. MOTHER'S MAIDEN NAME: Christina Koneig

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| NO | (?) | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post operative pneumonectomy — DUE TO intracranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Bronchiectasis - multiple abscesses — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct. 28, 1948 ? 49 | Bronchiectasis - R. Lung | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Oct 14, 1949 *to* Oct. 28, 1949 *that I last saw the deceased alive on* Oct. 28, 1949 *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. D. Penn M. D. | Mercy Hospital | Oct. 28 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 29 1949 | Mrs. Lucy [illegible] Registrar | Wm Fook Inc. 1217 St. Paul St |

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G79355

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

G79355
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD GARRICK

2. DATE OF DEATH: Oct. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 338 Stinson St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-04
D. STREET ADDRESS (If rural, give location): 338 Stinson St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | March 25, 1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer, unemployed | Farming | Lutherville, Md. | |

13. FATHER'S NAME: John Garrick

14. MOTHER'S MAIDEN NAME: Mary Walch

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | None | Mrs Margaret Dumhart, 338 Stinson St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 1, 1949 *to* Oct 27, 1949 *that I last saw the deceased alive on* Oct 27, 1949 *and that death occurred at* 6 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathan Bozman, M. D. | 206 S. Gilmor St. | 10.28.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | St. Joseph | Texas, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 29 1949 | Lucretia Williams M.D. | William Cook, Inc., 1217 St. Paul St. |

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G79356

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79356

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) ELLA B. SEITZ | 2. DATE OF DEATH Oct. 27, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 817 Park Ave. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-02 |
| c. Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 817 Park Ave. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Aug. 31, 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Musician, Unemployed | | Martinsburg, W. Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James D. Gletner | Mary A. Blankey |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 216-28-4217 | James M. Seitz, 817 Park Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular - renal Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Coronary Thrombosis — 10 hours

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | No | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-7-, 1949 *to* 10-27, 1949 *that I last saw the deceased alive on* 10-27, 1949, *and that death occurred at* 7.30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. A. Snodgrass M. D. | 1109 N. Calvert St. | 10-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | St. Johns | Frederick, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 29 1949 | Registrar for Baltimore City | William Cook, Inc., 1217 St. Paul St. |

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G79357 ✓ G79357

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) GEORGE WASHINGTON HOBBS | 2. DATE OF DEATH Oct. 27, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3115 Fleet St. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-02 |
| c. Length of stay in Baltimore Yrs. 50yrs Mos. Days | D. STREET ADDRESS (If rural, give location) 3115 Fleet St. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 25, 1871 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | H.B. Davis Co. | Harrisburg, Pa. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Caleb Hobbs | Irene Wickert |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 218-07-1785 | Mrs Louisa H. Hobbs, 3115 Fleet St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ascending Pulmonary Edema & Cyst — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Chronic Myocarditis — 7 Yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 24 1949 *to* Oct 27 1949 *that I last saw the deceased alive on* ____ 19__ *and that death occurred at* ____ *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hugh H. Hubbs M. D. | 3373 E. Baltimore St | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| OCT 29 1949 | Penelope Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

93D

G79358

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79358

Registered No.

1. NAME OF DECEASED (Type or Print): John W. Jones

2. DATE OF DEATH: Oct 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 madison ave
c. Length of stay in Baltimore: Bar - Wil - La Sparrow's Home — Yrs. Mos. Days: life

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 14-02
D. STREET ADDRESS (If rural, give location): 1536 Shields PL.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | c | Widowed | Aug 12, 1894 | 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Zechariah Jones
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: John Young — ADDRESS: 200 Bethel ct

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic heart disease. — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — , 19__, *to* — , 19__, *that I last saw the deceased alive on* — , 19__, *and that death occurred at* 1 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Bernard Benjamin M. D.
23B. ADDRESS: 834 Eliza St.
23C. DATE SIGNED: 10/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-29-49
24C. NAME OF CEMETERY OR CREMATORY: arbutus
24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George B. Kelson — ADDRESS: 1303 Pennsylvania ave

VS 150

937

G79359 ✓ G79359

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 51

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Joseph Serra**

2. DATE OF DEATH **Oct. 27 1949**

3. PLACE OF DEATH: A. Baltimore City, Maryland **1205 Peplar Grove St.**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ✓

c. Length of stay in Baltimore **56** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 16-07
D. STREET ADDRESS (If rural, give location) **1205 Peplar Grove St.**

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| **Male** | **White** | **Married** | **June 15 1876** | **73** | **4** | **12** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **Tailer** | **Tailer Shop** | **Ielsi-Campobasso- Italy** | **U.S.** |

13. FATHER'S NAME **Pasquale Serra**

14. MOTHER'S MAIDEN NAME **Marianna Penn**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | **215-01-6824** | **Anthony M.Serra(Son)** | **2202 Peplar Grove St** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **General Abdominal Carcinoma primary to** — INTERVAL BETWEEN ONSET AND DEATH: **Sept 1-1949**

DUE TO

(B) **site Stomach** — **Oct 27-1949.**

DUE TO

(C) **Malignant Cachexia**

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| **Oct 15-1949** | **Inoperative Abdominal Carcinoma** | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| **no** | ✓ | ✓ |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| ✓ m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | ✓ |

22. *I hereby certify that I attended the deceased from* **Sept 1**, 19**49** to **Oct 27**, 19**49**, *that I last saw the deceased alive on* **Oct 27**, 19**49**, *and that death occurred at* **8.50 A** m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **John A Rowland** M. D. | **1219 Peplar Grove St** | **10/28/49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Oct. 31 1949** | **New Cathedral Cemetery 4300 Old Frederick Rd** | **Balt. Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| **Oct 31 1949** | **Washington Williams, M.D.** | **Frank Zeller Sons** | **322 S.High St.** |

VS 150

46 B

G79360

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79360

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James P. McCormick

2. DATE OF DEATH: Oct. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 633 S. Potomac St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-02
D. STREET ADDRESS (If rural, give location): 633 S. Potomac St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | April 3, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Liquor Board | Baltimore | |

13. FATHER'S NAME: Thomas

14. MOTHER'S MAIDEN NAME: Ellen Stanton

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Nellie L. McCormick | 633 S. Potomac St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb. 9 1949, *to* Oct. 28, 1949 *that I last saw the deceased alive on* Oct. 15, 1949, *and that death occurred at* 12:15 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Tranchee M. D. | 103 W. Calvert St. | Oct. 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Baltimore | North Ave & Rose St. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 29 1949 | [illegible] | Clarence F. Hoffmann | 1639 Broadway. |

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G79561 ✓ X G79561

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 157E

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jay H. Keyser Jr.

2. DATE OF DEATH: OCT 28 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland [redacted]

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Ky. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Louisville

D. STREET ADDRESS (If rural, give location): 160 Pennsylvania Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

c. Length of stay in Baltimore: 0 Yrs. Mon. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | Sept 1st 1948 | 1 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Ky | |

13. FATHER'S NAME: Jay H Keyser

14. MOTHER'S MAIDEN NAME: Jane H. Keyser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT [redacted] ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary edema | 1 hour |
| DUE TO (B) | Congestive heart failure | 2 days |
| DUE TO (C) | Tetralogy of Fallot | Congenital |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Post-operative pneumonia — 1 day

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/26/49 | Tetralogy of Fallot | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-24 1949 *to* 10-28 1949, *that I last saw the deceased alive on* 10-28 1949, *and that death occurred at* 7:15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard T. Griffith Jr. M. D. | [redacted] | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/1/49 | Cave Hill Cem | Louisville Kentucky |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 29 1949

REGISTRAR'S SIGNATURE: [redacted] Baltimore, Md.

25. FUNERAL DIRECTOR ADDRESS: Charles P. Lovell Co 2427 Monument Ave

VS 150

G79362 BALTIMORE CITY HEALTH DEPARTMENT G79362

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH MORRIS
2. DATE OF DEATH: October 26, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: 40 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D STREET ADDRESS (If rural, give location): 616 Bradley Street
5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan 16, 1907
9. AGE (In years last birthday): 42 — If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): N.J
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Morris
14. MOTHER'S MAIDEN NAME: Mollie Bland.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
16. SOCIAL SECURITY NO
17. INFORMANT: Cecelia Sutton ADDRESS: 2128 David Hill

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pericardial hemorrhage, due to

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ruptured aneurysm of aorta.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☒ NO ☐
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 10/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 25, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 29 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Wm. J. Whetman Jr. ADDRESS: 1101 McCulloh St. 207

VS 151

BIRTH NO. G79,563

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79,563

1. NAME OF DECEASED (Type or Print): Emma E. Athey

2. DATE OF DEATH: Oct. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3743 Beech Ave.
C. Length of stay in Baltimore: 51 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 12-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto c Md.
D. STREET ADDRESS (If rural, give location): 3743 Beech ave Balto. Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | W | Aug 17-1857 | 92 | | 11 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Va. | U.S.A. |

13. FATHER'S NAME: Wm. W. Athey

14. MOTHER'S MAIDEN NAME: Isabella Rinker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wm. H. B. Athey ADDRESS: 2504 St. Paul St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: Oct. 28, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 30/49 | Leesburg Va | Leesburg Va |

DATE RECEIVED BY LOCAL REGISTRAR: 29

REGISTRAR'S SIGNATURE: Tunstall for Wm. H. Hall M.D.

25. FUNERAL DIRECTOR: John D. Mitchell & Sons ADDRESS: 600 Eutaw Place

VS 151

937

G79364 JL 118036 ✓ G79364

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank Walther (WALTER)

2. DATE OF DEATH: 10-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals
c. Length of stay in Baltimore: Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-12
D. STREET ADDRESS (If rural, give location): 844 Rienhart St.-30

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Nov. 10, 1867 | 81 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper on coal truck
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian Walther
14. MOTHER'S MAIDEN NAME: Canecunda Hopp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none
17. INFORMANT: B. C. H. Records, ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Tuberculosis far advanced | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis Generalized | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ No NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-9-48, 19__, *to* Oct. 28, 1949, *that I last saw the deceased alive on* Oct. 28 1949, *and that death occurred at* 12.40PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: G. B. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 10-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: October 31
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): 3801 Frederick Ave. City Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 29 49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robt C. & Beulah M. Walters ADDRESS: 120 E. Franklin

VS 150

13B

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 760

BIRTH NO. Registered No.

NAME OF DECEASED (Type or Print): Rosalie Jackson

2. DATE OF DEATH: OCT 28 1949

PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Charles
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Doncaster
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Married | 9-27-18 | 31 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Dent
14. MOTHER'S MAIDEN NAME: Julia Mathews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Diabetes Mellitus? | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pregnancy | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-27 19__, *to* 10-28 19 49, *that I last saw the deceased alive on* 10-28 19 49, *and that death occurred at* 12 30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mason C. Andrews M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/1/49 | Mt. Zion Cemetery | Charles Co-Ironside, Md. |

| SIGNATURE OF LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Penelope Worthington for Williams, M.D. | Charles R. Law | 802 Mad. Ave. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 54.0 Registered No.

1. NAME OF DECEASED (Type or Print): Roger DeGallais

2. DATE OF DEATH: OCT 28 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland [illegible]

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Hainaut B. COUNTY Belgium
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hiers 7-5
D. STREET ADDRESS (If rural, give location) 12 Rue Blanche

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH: 7-26-43 | 9. AGE (In years last birthday): 6 | If under 1 year: Months Days | If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Belgium | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gaston Louis DeGallais | 14. MOTHER'S MAIDEN NAME: Eve Leveque

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour ?

DUE TO

(B) Post-operative Tetralogy of — Congenital

DUE TO Fallot

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10/22/49 | 19B. MAJOR FINDINGS OF OPERATION: Tetralogy of Fallot | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2- 1949 *to* 10-28- 1949 *that I last saw the deceased alive on* 10-28 1949 *and that death occurred at* 10:30 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Howard A. Tuffier M. D. | 23B. ADDRESS [illegible] | 23C. DATE SIGNED: 10/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: Oct 29-49 | 24C. NAME OF CEMETERY OR CREMATORY: New York city | 24D. LOCATION (City, town, or county) (State): N. Y.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949 | REGISTRAR'S SIGNATURE: [illegible] Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS: John D. Mitchell & Sons 1900 Eutaw Pl. 157E

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

G79367

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Katherine Grimes

2. DATE OF DEATH: Oct. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 804 E. Lombard Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col | Widowed | Nov. 20, 1887 | 61 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unknown | | Unknown | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Records | Good Samaritan Hosp. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Hypertensive cardio-vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Possible malignancy of lt. lung.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 Oct 1949 *to* 26 Oct 1949, *that I last saw the deceased alive on* 26 Oct 1949, *and that death occurred at* 2 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil H. Henning Jr. M. D.

23B. ADDRESS: 4580 Edmondson Ave

23C. DATE SIGNED: 28 Oct 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Oct. 29, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): Brooklyn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: Oct. 30 1949

REGISTRAR'S SIGNATURE: Hunter Lyon Williams M.D.

25. FUNERAL DIRECTOR: Joseph L. Russ

ADDRESS: 1200 McCulloh St., Balt, Md.

VS 150

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G79368 G79368

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Hamilton, Robert Wilmer

2. DATE OF DEATH October 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
The Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-06
D. STREET ADDRESS (If rural, give location) 2600 Hamilton Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | Dec. 10, 1905 | 43 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Male Nurse | | Maryland. | United States |

13. FATHER'S NAME
George E Hamilton

14. MOTHER'S MAIDEN NAME
Rosa Schnaitman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
Unknown

16. SOCIAL SECURITY NO. 212-09-1251

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Multiple Pulmonary Infarcts | Unknown |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Mural thrombus of right ventricle of heart | Unknown. |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* September 10, 1949, *to* October 27, 19__, *that I last saw the deceased alive on* October 27, 1949, *and that death occurred at* 10:00 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Merrell F. Nelson M. D. | Union Mem. Hosp. | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 43

1. NAME OF DECEASED (Type or Print): BESSIE, A. LOGAN.

2. DATE OF DEATH: October 27-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2529-Mc! Henry St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 36 yrs). (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - 20-04
D. STREET ADDRESS (If rural, give location) 2529-Mc! Henry St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed. | Jan. 12-1878 | 71 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife -
10B. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Winchester - Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Frank Jefferson.
14. MOTHER'S MAIDEN NAME: Laura V. Barlington.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no. no.
16. SOCIAL SECURITY NO.: no.
17. INFORMANT: Mrs. Gladyse. Kerbe ADDRESS: 2541 Mc Henry St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | (INTERVAL BETWEEN ONSET AND DEATH) |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Pulmonary Edema | 3 Hrs. |
| DUE TO (B) | Artero Sclerotic Cardio Vas. Dis. | 10 yrs. |
| DUE TO (C) | Hypertension in Cardio Vasc. Dis. | 20 yrs. ? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/9, 1949, to 10/28, 1949 *that I last saw the deceased alive on* 10/28, 1949, *and that death occurred at* 12 A *m., from the causes and on the date stated above.*

23A. SIGNATURE, M. D.: Maurice C. Bogrod
23B. ADDRESS: 1905 W. Balto. St.
23C. DATE SIGNED: 10/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: Oct. 31-1949.
24C. NAME OF CEMETERY OR CREMATORY: London Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Charles J. Schwabe ADDRESS: 3512 Fredk Ave

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 37

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Peter J. McGraw

2. DATE OF DEATH: Oct. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Just Arrived Home — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: West Virginia
B. COUNTY: Marion
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Farmington
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug. ? 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Ireland | USA |

13. FATHER'S NAME: Peter Mc Graw

14. MOTHER'S MAIDEN NAME: Mary Crosgrove

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| Unknown Unknown | Unknown | Marshall Patrick - Farmington W Va |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Softening — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct. 27, 1949 | Incised Intracranial Pressure | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 27, 1949 *to* Oct. 29, 1949, *that I last saw the deceased alive on* Oct. 29, 1949, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | Mercy Hospital | Oct. 29, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Farmington | West Virginia |

DATE RECEIVED BY LOCAL REGISTRAR: 10/31/49 — REGISTRAR'S SIGNATURE: [signature] Huntington, W. Va. — 25. FUNERAL DIRECTOR / ADDRESS: R. W. Meeks and Son 805 N. Calvert St

VS 150

83c

G79.71 ✓ G79.71

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50.0

Registered No.

1. NAME OF DECEASED (Type or Print): Lavinia M. Kahn

2. DATE OF DEATH: Oct. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5D, Esplanade Apt.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 75 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
5D, Esplanade Apt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland 13-01
D. STREET ADDRESS (If rural, give location): Eutaw Place & Brooks Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | White | Widowed | April 22, 1874 | 75 | 6 | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Maryland | U.S. |

13. FATHER'S NAME: Jacob Miller

14. MOTHER'S MAIDEN NAME: Henreitta Frank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Frank Kahn, ADDRESS: 2213 South Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B) Arterio-sclerosis — 5 yrs
DUE TO
(C) ~~Paget's Disease~~ — ~~5 yrs~~

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Paget's Diseases — 5 yrs 2 Mos

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| ✓ | ✓ | ✓ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | ✓ | ✓ |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| ✓ | | ✓ |

22. *I hereby certify that I attended the deceased from* 1942, 19__, *to* Oct 28, 1949 *that I last saw the deceased alive on* Oct 28, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Frederick Leitz M. D. | Temple. Gardens | Oct 29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 30, 1949 | Baltimore Hebrew | Belair Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 29 1949 | Huntington Williams, M.D. | David Sondheim Son. | 1902 Eutaw Place |

DAVID SONDHEIM & SON
1902 Eutaw Place

VS 150

155

G79:372 G79:372

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Frances Priscilla Canter

2. DATE OF DEATH: Oct. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1720 Thomas Ave.,

c. Length of stay in Baltimore: 30 -- Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-03
D. STREET ADDRESS (If rural, give location): 1720 Thomas Ave.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 20, 1851 | 98 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Md. | |

13. FATHER'S NAME: Thomas T. Birch

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| NO | none | Mr. Francis T. Canter 1720 Thomas Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 1938

DUE TO

(B) Chr. Interstitial Nephritis — 1938

DUE TO

(C) Arteriosclerosis — 1938

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 8, 1944 *to* Oct. 27, 1949 *that I last saw the deceased alive on* Oct. 27, 1949 *and that death occurred at* 2:15 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jane Brown M. D. | 1663 W. North Ave. | 10-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-30-49 | All Faith Episcopal | St. Mary's Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 29 1949 | Huntington Williams, M.D. | G. Howard Strong 3207 W. North Ave., |

VS 150

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BIRTH NO. G79373

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1957

3 G79373 Registered No.

1. NAME OF DECEASED (Type or Print): Everett Pederson

2. DATE OF DEATH: 10/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 2 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY 13-12
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 613 Lemmon St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 9/14/27 | 22 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boston Mass
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Andrew H Pederson
14. MOTHER'S MAIDEN NAME: Margy Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): N Knk
16. SOCIAL SECURITY NO. 228-14-2821
17. INFORMANT: Mr Everett Pederson ADDRESS: 2626 Druid Park Dr.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral pyonephrosis & hydronephrosis & uremia — INTERVAL BETWEEN ONSET AND DEATH: hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pancreatitis, hydrocholecystitis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/24, 1949, *to* 10/27, 1949, *that I last saw the deceased alive on* 10/27, 1949 *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Richard Frank M. D. | Mercy Hosp. | 10/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-30-49 | Mt. Olivet Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams, M.D. | John C. Melby Sons | 2425 E. Oliver St. |

VS 150
OCT 30 1949

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CERTIFICATE CORRECTED 11-30-49 ✓ G79374

BIRTH NO. G79374

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Louis MERKEL
2. DATE OF DEATH: 10-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1650 No Smallwood St
C. Length of stay in Baltimore: 60 Yrs. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-03
D. STREET ADDRESS (If rural, give location): 1650 No Smallwood St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Oct. 23 1887
9. AGE (In years last birthday): 62 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Shirts
11. BIRTHPLACE (State or foreign country): Germany Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Morris
14. MOTHER'S MAIDEN NAME: Esther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Etta Merkel ADDRESS: 1650 N Smallwood

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis DUE TO
(B) Hypertension arteriosclerosis DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/20 19 49 *to* 10/28 19 49, *that I last saw the deceased alive on* 10/27 19 49, *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: David Strauber M. D.
23B. ADDRESS: 122 W Lee St
23C. DATE SIGNED: 10/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10-30-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 30 1949
REGISTRAR'S SIGNATURE: Lexington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewin Inc
ADDRESS: 2100 Eutaw Pl

VS 150

94a

Dr Levi G79375
1605 Broadway
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79375

1. NAME OF DECEASED (Type or Print): William Eugene Fisher
2. DATE OF DEATH: 10/29/1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1729 E. 32nd St.
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 1729 E. 32nd Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan 25-1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | News Post | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Fisher | Margaret Kane |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs. Augusta Fisher - 1729 E. 32nd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Occlusion | 8 hrs. |
| DUE TO (B) | Arteriosclerosis | 4 yrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 10, 1947, *to* Oct. 28, 1949, *that I last saw the deceased alive on* Oct. 28, 1949, *and that death occurred at* 3:30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ernest Levi, M. D. M. D. | 1605 N. Broadway | 10/28/49 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Parkwood | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| OCT 30 1949 | Theodore Williams M.D. | Leonard J. Luck 5305 Harford. |

94a

G79376 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT 03

# CERTIFICATE OF DEATH

G79376 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES WHALEN ROBERTS

2. DATE OF DEATH October 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena P. O.
D. STREET ADDRESS (If rural, give location) Orchard Beach

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Mar. 3, 1906 | 43 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pipe Fitter | Plumbing | New York City, N. Y. | |

13. FATHER'S NAME Robert Roberts

14. MOTHER'S MAIDEN NAME Catherine Monahan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 059-05-9791 | Mrs. Pauline Roberts | Orchard Beach Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO Luetic aortitis with coronary osteol stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | | Oct. 29, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 10/30/49 | Green Grove Cem. | Keyport, N. J. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 30 1949 | Assistant for Registrar | WM. J. TICKNER & SONS | Balto., Md. |

S-151

30D ✓

B-132495 G79377 5 40. 0

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No. G79377

1. NAME OF DECEASED (Type or Print): Joseph Gessner

2. DATE OF DEATH: 10-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 28 days? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01
D. STREET ADDRESS (If rural, give location): 113 S. Paca St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | 6/19/1890 | 59? | 4 | 9 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Wholesale Auto Supply Co
11. BIRTHPLACE (State or foreign country): Germany Rumania
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Alban Gessner
14. MOTHER'S MAIDEN NAME: Christine Schlegel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Shock | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Bleeding Gastric Ulcer | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (over) | |

19A. DATE OF OPERATION: 10-26-49
19B. MAJOR FINDINGS OF OPERATION: Ruptured peptic ulcer
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30, 1949, *to* 10-28, 1949 *that I last saw the deceased alive on* 10-28, 1949, *and that death occurred at* 5.40P m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10-29-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/31/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 30 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul st.

VS 150

117a

G79378

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79378

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): M. M. Gordon

2. DATE OF DEATH: 10/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp Inc.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE [redacted] Md. B. COUNTY Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 22-02
D. STREET ADDRESS (If rural, give location): 655 Washington Blvd # 30

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED | 8. DATE OF BIRTH: 6/6/86 | 9. AGE (In years last birthday): 63 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Steamstress Morris & Co
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? yes - USA

13. FATHER'S NAME: Richard Jepp
14. MOTHER'S MAIDEN NAME: Mary Church

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 579-07-2077
17. INFORMANT: Israel M. Gordon ADDRESS: 655 Washington Blvd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Profound ileus (intestinal) — INTERVAL BETWEEN ONSET AND DEATH: 10/23 to 10/29/49
DUE TO (2) Possible obstruction - adhesions abd. surgery

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Adhesions and surgery — INTERVAL BETWEEN ONSET AND DEATH: 10/24 to 10/29
DUE TO Perform od for same as well as for right ovary cyst.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Auricular fibrillation

19A. DATE OF OPERATION: 10/21/49
19B. MAJOR FINDINGS OF OPERATION: Adhesions of bowel to bowel; 6-8 cm Rt ovarian cyst.
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct 24, 1949, *to* Oct 29, 1949, *that I last saw the deceased alive on* Oct 29 1949 *and that death occurred at* 5 05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 10/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 1, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Lawn Memorial
24D. LOCATION (City, town, or county) (State): Taylor Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 28 1949
REGISTRAR'S SIGNATURE: [signature] Registrar of Vital Statistics, Md.
25. FUNERAL DIRECTOR: A. Howard Evans & Son
ADDRESS: 1400 Lombard

VS 156

56a

G79379

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79379

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth G.Madden

2. DATE OF DEATH: 10-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3714 Gibbons Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
27-34
D. STREET ADDRESS (If rural, give location): 3714 Gibbons Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 8-15-1874 | 75 | 3 / 13 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Thomas Kennedy

14. MOTHER'S MAIDEN NAME: Mary Ward

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | None | None |

17. INFORMANT: Mrs.Catherine C.Fonte — ADDRESS: 3714 Gibbons Ave. Balto:Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Thrombosis | none |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerotic C.V.D. | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 5/2/49. | Thyroidectomy - Toxic Goiter | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4/15, 1949, *to* 10/28, 1949, *that I last saw the deceased alive on* 10/30, 1949, *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. J. Battaglia M. D. | 5829 Belair Rd | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-31-49 | New Cathedral Cemetery | Edmondson Ave.Balto:Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| OCT 30 1949 | Remington Williams, M.D. | George J.Ruth, Inc.-1735 Harford Ave. |

VS 150

638

G79380

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G79380

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Ida Wallace

2. DATE OF DEATH: Oct. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland acc. Room
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkin Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 25-05
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Hawthorne Pl. Rd.
D. STREET ADDRESS (If rural, give location): 3408 Hawthorne Rd

5. SEX: female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St Marys Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Samuel Allison
14. MOTHER'S MAIDEN NAME: Athea Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Geo. Wallace
ADDRESS: 3408 Hawthorne Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerotic cardiovascular disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26, 1949, *to* 10/26, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edgar M. Schumacher M. D.
23B. ADDRESS: J. H. H.
23C. DATE SIGNED: 10/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 30 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 30 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams M.D.
25. FUNERAL DIRECTOR: Robert Williams
ADDRESS: 155 McCulloh St

93D

150

G79381

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79381

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine M. Rosemer

2. DATE OF DEATH: Oct. 28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1903 E. Oliver St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1903 E. Oliver St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | Widow | Nov. 23, 1859 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | Own Home | Md. | |

13. FATHER'S NAME: Kircher

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Mr. John S. Rosemer, 2710 N. Howard St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio Vascular Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* [illegible] 1947 *to* Oct. 1949, *that I last saw the deceased alive on* Oct. 27 1949, *and that death occurred at* 6 P. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Konnerth, Jr. M. D. | 501 Sheridan Ave. | Oct. 30, '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 31/49 | Holy Redeemer | Belair Rd. Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE: Courtesy for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Harry H. Mintz, 2201 Edmondson Ave.

VS 150

OCT 30 1949

93D

G79582

G79582

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Geany Sister Laurent (HONORA GEANEY)

2. DATE OF DEATH: 10/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2000 W. Baltimore St. Baltimore Md.
c. Length of stay in Baltimore: 30 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23
D. STREET ADDRESS (If rural, give location): 2000 W. Baltimore St.

20-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | 1/13/73 | 76 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Religious | Nursing | Ireland | Irish |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| — | — |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Bon Secours Convent | 2000 W. Balt St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Occlusion | 1 Hr. |
| DUE TO (B) | Hypertension — | 10 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Arterio-Sclerosis, Generalized | 10 yrs. |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10 Aug., 1949 *to* 29 Oct., 1949 *that I last saw the deceased alive on* 29 Oct., 1949, *and that death occurred at* 11a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph R. Dolce M. D. | Bon Secours Hosp. Balt. Md. | 29 Oct. '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-31-49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | [illegible] | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | [illegible] | George A. Farley | 1412-14 Eutaw & 2 Smyth St. |

94a

G79383

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79383 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY ESCHBACH

2. DATE OF DEATH: 10/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4515 Garrison Blvd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Haven Nursing Home
C. Length of stay in Baltimore: 87 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-02
D. STREET ADDRESS (If rural, give location): 2407 Lauretta Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | W | 12/15/1861 | 87 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Eschbach
14. MOTHER'S MAIDEN NAME: 2

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Family-Same ADDRESS: Clarke Keelson 2407 Lauretta

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Terminal Bronchopneumonia | 1 Week. |
| DUE TO | | |
| (B) | Senile Arteriosclerosis | 1 Year |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [+] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [+] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 28, 1949 *to* Oct 28, 1949 *that I last saw the deceased alive on* Oct 28, 1949 *and that death occurred at* 4:35 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: L. A. Lally MD M. D.
23B. ADDRESS: 357 Edmondson Ave
23C. DATE SIGNED: Oct 29, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) / (State) |
|---|---|---|---|
| B | 10/31/49 | Druid Ridge | Pikesville |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: James L. McCauley ADDRESS: 130 E. Fort Ave.

VS 150

97

BIRTH NO. G79384 49-23 191

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79384

1. NAME OF DECEASED (Type or Print): Baby Boy Chepko, Kenneth Paul
2. DATE OF DEATH: Oct. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. For The Women of Md.
C. Length of stay in Baltimore: one Days

USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): 151 E. Main Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 29, 1949 | | 1 | 3 / 27 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Maryland | USA. |

13. FATHER'S NAME: Julius Chepko
14. MOTHER'S MAIDEN NAME: Maida Jean Watt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | none | Mrs. Julius Chepko | 151 E. Main St. Westminster, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple intracranial venous sinus thrombus

DUE TO

(B) Intra cranial hemorrhage

DUE TO

(C) Birth injury

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 29 1949 *to* Oct. 30, 1949 *that I last saw the deceased alive on* Oct. 30, 1949 *and that death occurred at* 6 15/a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Spencer, Jr. M. D. | Hosp. for Women of Md. | 10-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 1, 1949 | Westminster | Westminster Md, |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 30 1949 | Huntington Williams, M.D. | David Bankard | Westminster, Md |

VS 150

160a

9385

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79385 Registered No.

BIRTH NO.

KATHERINE E. McKENNA

1. NAME OF DECEASED (Type or Print): Miss KATHERINE McKENNA

2. DATE OF DEATH: 10/28/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland — Md. Genl. Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Genl Hosp.

c. Length of stay in Baltimore: 11 Yrs. 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 730 E. North avenue

5. SEX: F
6. COLOR OR RACE: Wh.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single.
8. DATE OF BIRTH: Feb. 18, 1890
9. AGE (In years last birthday) If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.: 58 yrs.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John C. McKenna
14. MOTHER'S MAIDEN NAME: Mary J. Gahagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Joseph L. Gahagan
ADDRESS: ~~6809 Craig avenue~~

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Atelectasis.
DUE TO
(B) Chronic Cholecystitis.
DUE TO
(C) Post Operative.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 10/11/49.
19B. MAJOR FINDINGS OF OPERATION: Chr. Cholecystitis & Lithiasis
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/10, 1949 *to* 10/28, 1949 *that I last saw the deceased alive on* 10/28, 1949 *and that death occurred at* 3:40 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ernest C. Krasans M. D.
23B. ADDRESS: Md. Genl Hosp
23C. DATE SIGNED: 10/28.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct. 31/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. J. Evans & Son Inc.
ADDRESS: 118 West Mount Royal avenue

VS 150

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G79386

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

51

G79386

Registered No.

BIRTH NO. 49-22893

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Infant Bosse | 2. DATE OF DEATH: Oct. 23, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital<br>c. Length of stay in Baltimore: Yrs. Mos. Days | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A STATE: Maryland<br>B COUNTY<br>C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore<br>D STREET ADDRESS (If rural, give location): 831 S. Linwood Ave. # 24 |
| 5. SEX: Female<br>6. COLOR OR RACE: White<br>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S | 8. DATE OF BIRTH: Oct. 23, 1949<br>9. AGE (In years last birthday)<br>If Under 1 Year: Months, Days<br>If Under 24 Hours: Hours, Min. 7 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)<br>12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: Walter Michael Bosse | 14. MOTHER'S MAIDEN NAME: Raymonda Marie Seffeyerth |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Mother 831 S. Linwood Ave. # 24 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Craniorachischisis with meningomyelocele. | — |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bilateral club foot | — |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ✓ NO |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Oct 23 1949 *to* Oct 23 1949 *that I last saw the deceased alive on* Oct 23 1949 *and that death occurred at* 6 A.M. *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE: Irwin H. Kaiser, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL<br>24D. LOCATION (City, town, or county) (State): OCT 28 1949 |
| DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Commissioner of Health<br>ADDRESS |

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157B

G79387

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-2248 — 774 Registered No. G79387

1. NAME OF DECEASED (Type or Print): Smith

2. DATE OF DEATH: Oct. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1414 N. Linwood Ave # 13

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Oct. 16, 1949
9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min.: 3

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edgar Smith
14. MOTHER'S MAIDEN NAME: Audrey Blondheim

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mother — ADDRESS: 1414 N. Linwood Ave. #13

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Immaturity less than 1000 grams. — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) Premature birth - Neo-natal death.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 16 1949 *to* Oct 16, 1949 *that I last saw the deceased alive on* Oct 16, 1949 *and that death occurred at* 4:44 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Harry Wexstein M. D.
23B. ADDRESS: 2359 Eutaw Place
23C. DATE SIGNED: 10/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal by Hospital
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL OCT 28 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

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G79588

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

776

Registered No. G79588

BIRTH NO. 49-22900

1. NAME OF DECEASED (Type or Print): Infant Friesland

2. DATE OF DEATH: Oct. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River
D. STREET ADDRESS (If rural, give location): 55 Llewellyn Ave. Box. 32, Middle River, Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | S | Oct. 24, 1949 | | | 6 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Roy Gene Friesland

14. MOTHER'S MAIDEN NAME: Mary Margaret Pellicone

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | 55 Llewellyn Ave. Box 32 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Middle River, Md.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-24-49 19 , *to* 10-24 , 1949 *that I last saw the deceased alive on* 10-24 , 1949 *and that death occurred at* 2:00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John M. Gealer M.D. | Sinai Hospital Baltimore | 10-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL OCT 28 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

159

775388 CERTIFICATE CORRECTED 11-3-49 ✓ X 775388

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No 3 ✓ Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Moses Ralph Wright

2. DATE OF DEATH October 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glen Burnie
D. STREET ADDRESS (If rural, give location) 18 D St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Feb 12 - 121888 | 61 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | | Virginia | |

13. FATHER'S NAME Walter Wright

14. MOTHER'S MAIDEN NAME Eddie Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO

17. INFORMANT Helen A. Wright (wife) ADDRESS Glen Burnie

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia & coma | 2 weeks |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Neoplasm & generalized metastases to liver, lung & ribs | Unknown |
| DUE TO | Multiple Myeloma? Pending microscopic Sections | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Myelophthisic anemia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 10-9, 1949 *to* 10-28, 1949 *that I last saw the deceased alive on* 10-27, 1949, *and that death occurred at* 12:00 m. (night) *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Candler, M. D. | Maryland General Hospital | 10/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 31, 1949 | Glen Haven | Glen Burnie A.A.Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS Glen Burnie

VS 150

55E

G79390

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79390

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Leffet — 2. DATE OF DEATH: October 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Sanatarium
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Odenton
D. STREET ADDRESS (If rural, give location): Jacksons Grove

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 30 1876 | 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Germany Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob Leffet
14. MOTHER'S MAIDEN NAME: Catherine Steinacher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Esther M. Leffet — ADDRESS: Odenton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | ? |
| DUE TO | Non Rheumatic Cardiac Asthma | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Generalized arteriosclerosis | ? |
| DUE TO | Cerebral arteriosclerosis | 1 year |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Bronchopneumonia, Bilateral | 3 days |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 10, 1949, to October, 1949 *that I last saw the deceased alive on* October 29, 1949, *and that death occurred at* 10:40 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Burden M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 10/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 1 1949
24C. NAME OF CEMETERY OR CREMATORY: Nichols Bethel
24D. LOCATION (City, town, or county) (State): Odenton, A.A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Thomas W. Singleton — ADDRESS: Ehrmi Burnie

VS 150

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G79391

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

63

G79391

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): HENRY JOHN LOTTES

2. DATE OF DEATH: Oct. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 766 Linnard St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-08
D. STREET ADDRESS (If rural, give location): 766 Linnard St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Mar. 1, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired Clerk | Court House | Baltimore, Md. | |

13. FATHER'S NAME: John Henry Lottes

14. MOTHER'S MAIDEN NAME: Barbara -

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. William M. Lottes | 506 GlenAllen Dr. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Chronic valvular heart disease — unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March, 1947, *to* Oct. 28, 1949 *that I last saw the deceased alive on* Oct 28, 1949, *and that death occurred at* 5:20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. E. Wells M. D. | 4100 Edmondson Ave | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Meadowridge Cem. | Howard Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Henrietta for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

471

G79392 ✓ G79392

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

774 Registered No.

BIRTH NO. 49-21474

1. NAME OF DECEASED (Type or Print): DONALD LEIGH CARE

2. DATE OF DEATH: 10-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. 12 Mos. 03 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 301 Whitridge Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | S | 10-4-49 | | | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MARYLAND | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ROBERT FREDERICK CARE | PHYLLIS GRACE SIMMONS |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Phyllis Care | 301 Whitridge Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | BRONCHO PNEUMONIA | 3 days |
| DUE TO (B) | PREMATURITY | 26 days |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-4, 1949 *to* 10-30, 1949, *that I last saw the deceased alive on* 10-30, 1949 *and that death occurred at* 11:34 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter C. Fridez M. D. | Maryland Gen'l Hosp | 10/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Mt. Carmel | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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G79393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

176 Registered No. G79393

BIRTH NO. 49-22893

1. NAME OF DECEASED (Type or Print): Ann Elaine THORSSELL

2. DATE OF DEATH: 10-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore: 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hampstead
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | S | 10-19-49 | | | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | MARYLAND | U S |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| KARL ERIC ROGNAR THORSSELL | DOROTHY TOWNSEND |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mr. Karl Thorssell | Hampstead, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 10-19, 1949 *to* 10-29, 1949 *that I last saw the deceased alive on* 10-29, 1949, *and that death occurred at* 10:20A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter C. Finlay M. D. | Mercy Out Pat. Dept. | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Loudon Park Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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G79394

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79394 Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Marie Strauff

2. DATE OF DEATH: Oct 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 128 S. Hilton St.

C. Length of stay in Baltimore: 65 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 128 S. Hilton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | April 2, 1878 | 71 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Germany | |

13. FATHER'S NAME: Richard R. Uhlig

14. MOTHER'S MAIDEN NAME: Maria Eichler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | | — |

17. INFORMANT: Mrs. Richard Hopkins ADDRESS: 128 S. Hilton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | |
| DUE TO (B) | Cardio Vascular Renal Disease | 2 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 27, 1949 *to* Oct 28, 1949 *that I last saw the deceased alive on* Oct 28, 1949, *and that death occurred at* 9:10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Alpha H Lewarther M. D. | 4709 Fredonia Ave | Oct 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10/31/49 | Loudon Park Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

H 43 G79395 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosa Brown

2. DATE OF DEATH: OCT 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 40 yrs Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-03
D. STREET ADDRESS (If rural, give location): 617 Collington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Aug 7 1877 | 72 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | none | Md | |

13. FATHER'S NAME: William Iregas (TREGO)

14. MOTHER'S MAIDEN NAME: Rosa Vickers

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease 4 Years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For: Wm. H. Kammer, M.D.
R. B. Fowler M. D.
CHIEF OR ASST. MEDICAL EXAMINER.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-26 19 49 *to* 10-28 19 49 *that I last saw the deceased alive on* 19 *and that death occurred at* m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Sukeus M. D. | JOHNS HOPKINS HOSPITAL | 10-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct 31/49 | Oak Lawn Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Philip Herring Sons | 2824 Eastern Ave |

VS 150 Medical Examiner to be approved 93D

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G79396 Registered No.

1. NAME OF DECEASED (Type or Print): Martha F. McCoy
2. DATE OF DEATH: 10/29/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5313 Carter Ave
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-44
D. STREET ADDRESS (If rural, give location): 5313 Carter Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Dec. 11-1859 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Balto Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? Crawford | ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Wm. McCoy | 5313 Carter |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive cardio-vascular disease (years)

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 2, 1949 *to* Oct 28, 1949 *that I last saw the deceased alive on* Oct. 28, 1949, *and that death occurred at* 3:10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. V. Harbold M. D. | 4706 Harford Road | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-1-49 | Loudon Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5305 Harford |

VS 150

93D

G79397 G79397

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
585 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arabella Butler
2. DATE OF DEATH: OCT 29 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 16-07
c. Length of stay in Baltimore: 51 years (Yrs. Mon. Days)
D. STREET ADDRESS (If rural, give location): 2707 Ellicott Driveway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Widow | Sept. 1- 1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | — | Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Hamilton | Elizabeth Wesley |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | [illegible] Hopkins Hospital |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cholecystitis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Arteriosclerotic Hypertensive Heart Disease

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-28-49 | Acute Cholecystitis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-28- 1949 *to* 10-29- 1949 *that I last saw the deceased alive on* 10-29- 1949, *and that death occurred at* 6 34 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dewitt C. McEwan M. D. | [illegible] Hopkins Hospital | 10-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Nov. 1-1949 | St. Mary's (Hampden) | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Durgee Funeral Home | 3631 Falls Road |

VS 150

127a

G79398

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79398

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Florence Nickens 519346

2. DATE OF DEATH: OCT 30 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson,
D. STREET ADDRESS (If rural, give location): 403 Jefferson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colard | W. | 8-2-93 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | ? | Md. | U.S.A. |

13. FATHER'S NAME: James Hall Paul

14. MOTHER'S MAIDEN NAME: Sarah Nelson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT / ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 4 MINS.

DUE TO

ANTECEDENT CAUSES

(B) Cerebral anoxia — 24 HRS.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Post operative shock ? Uremia

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Possible uremia.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/29/49 | Acute cholecystitis | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 10-28-, 1949 to 10-30-, 1949 that I last saw the deceased alive on 10-30-1949, and that death occurred at 3:17 pm., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Allen K. Nelson M. D. | JOHNS HOPKINS HOSPITAL | 10/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Forbush Mem. Pk. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Wm. J. Chatman Jr. | 1901 McCulloh St. |

VS 150

127a

G79399

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 117

G79399

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) HARRY BARTRAM FRENCH

2. DATE OF DEATH October 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5216 Gwynn Oak Avenue -7-

c. Length of stay in Baltimore 68 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore -7-28-
D. STREET ADDRESS (If rural, give location) 5216 Gwynn Oak Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 27, 1880 | 68 | 11 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Advt. Mgr. Mfg. Record | Publishing | Maryland | U.S. |

13. FATHER'S NAME Charles F. French

14. MOTHER'S MAIDEN NAME Lauya V. Gaunt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| (If yes, give war or dates of service) No | 215-01-4575 | Mrs. Bessie French | 5216 Gwynn Oak Ave-7 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Prostate — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic cardio vascular disease 5 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| March 25, 1949 | Carcinoma of the Prostate | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 8 1949 *to* October 29, 1949 *that I last saw the deceased alive on* October 28 1949 *and that death occurred at* 2:25 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Millard T. Trabold Jr. M. D. | 3400 Woodbine Ave. Balt. 7, Md | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/1/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

51B

G79400

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79400

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE LANCASTER ALVEY

2. DATE OF DEATH: Oct. 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2722 N. Howard St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 12-06
D. STREET ADDRESS (If rural, give location): 2722 N. Howard St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan. 11, 1878 | 71 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10B. KIND OF BUSINESS OR INDUSTRY: Lord Balto. Press

11. BIRTHPLACE (State or foreign country): Matthews Co., Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George D. Alvey

14. MOTHER'S MAIDEN NAME: Ella Shackelford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Helen A. Nalte ADDRESS: Marion Station, Pa. 541 Prescott Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROSIS — DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 week

19A. DATE OF OPERATION: NONE

19B. MAJOR FINDINGS OF OPERATION: NONE

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): NONE

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): NONE

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): NONE m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NONE WHILE NOT AT WORK ☐

21F. HOW DID INJURY OCCUR? NONE

22. *I hereby certify that I attended the deceased from* Oct. 10, 1949, *to* Oct. 28, 1949, *that I last saw the deceased alive on* Oct. 28, 1949, *and that death occurred at* 7 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Stuart D. Sunday M. D.

23B. ADDRESS: 241 East 33rd St.

23C. DATE SIGNED: Oct 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/31/49

24C. NAME OF CEMETERY OR CREMATORY: Balto. Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

94a

G79401

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79401

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FLORENCE REBECCA CATHELL

2. DATE OF DEATH: Oct. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4203 Springdale Ave. Lewis Nursing Home

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-02
D. STREET ADDRESS (If rural, give location): 1628 N. Milton Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Jan. 28, 1883
9. AGE (In years last birthday): 66 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): never employed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James R. Cathell
14. MOTHER'S MAIDEN NAME: Mary E. Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Elsie C. Steinmann ADDRESS: 1628 N. MiltonAv

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

(B) Hypertensive cardio-vascular renal disease — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 Oct. 1949 *to* 30 Oct. 1949, *that I last saw the deceased alive on* 29 Oct. 1949, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis E. Wice M. D.
23B. ADDRESS: 920 St. Paul St.
23C. DATE SIGNED: 31 Oct. '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/1/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

121a

G79402

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 981

Registered No. G79402

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRIETTA JONES — N-853.4

2. DATE OF DEATH: October 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 12 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02
D. STREET ADDRESS (If rural, give location): 1702 McKean Avenue

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1937
9. AGE (In years last birthday): 12 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown.
14. MOTHER'S MAIDEN NAME: Elnora Jones.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Vernon Legon ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot wound of head — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1702 McKean Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): October 28, 1949 12.00 P.M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* partial autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 10/31/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): West Post Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Metropolitan Funeral Homes Inc. ADDRESS: 927 N. Mount St

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VS 151

G79403

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79403 Registered No.

BIRTH NO. ~~LEA DORCHIC~~

1. NAME OF DECEASED (Type or Print): LEA DORCHICOURT.

2. DATE OF DEATH: 10/30/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CHURCH HOME & HOSPITAL.
c. Length of stay in Baltimore: 24 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE.
D. STREET ADDRESS (If rural, give location): OLD BAY AV: FORT HOWARD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | White. | | 3.14.1880 | 69. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE. | | FRANCE. | U.S.A. |

13. FATHER'S NAME: AELLE BOUDVILLE.

14. MOTHER'S MAIDEN NAME: USTA.?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | none | Eugene Dorchicourt (son) | Ft. Howard Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PEMPHIGUS. — INTERVAL BETWEEN ONSET AND DEATH: 18 days.
DUE TO
(B) CANCER HEAD OF PANCREAS.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/12/, 1949 *to* 10/30/, 1949 *that I last saw the deceased alive on* 10/29/1949, *and that death occurred at* 3.40 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wayne R. Sowers MD. M. D. | Church Home Hospital | 10/30/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Oak Lawn Cem. | Eastern Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Thurlington for Williams, M.D. | Mildred J. Blighty | 6009 Harford Rd |

VS 150

469

G79404

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79404

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Francisyha Wojciechowski

2. DATE OF DEATH: Oct. 28. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1606 Aliceanna St

C. Length of stay in Baltimore: 48 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City 2-03
D. STREET ADDRESS (If rural, give location): 1606 Aliceanna St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | about 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

13. FATHER'S NAME: Bredka

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | alexander Markowski | 1606 Aliceanna St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Renal Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____ 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:55 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas C. Webb M.D. M. D. | 901 St Paul St | 10-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-2-1949 | Holy Rosary | Balto. Co. |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Wm. L. Fialkowski | 2007 Eastern Ave |

VS 150

131a

G79405

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79405

1. NAME OF DECEASED (Type or Print): James Jenkins
2. DATE OF DEATH: Oct 28 / 49

3. PLACE OF DEATH: A. Baltimore City / Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1410 Lemmon St
C. Length of stay in Baltimore: Yrs. 60 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 19-03
D. STREET ADDRESS (If rural, give location): 1410 Lemmon St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Widower | Mar 21, 1879 | 70 | 7 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Frederick Md. | |

13. FATHER'S NAME: James Jenkins Sr.
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Sophie Smallwood | 1410 Lemmon St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Disease — Interval between onset and death: 1 yr.
DUE TO
(B) Broken Compensation — 3 mo's
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 15, 19 48, *to* Oct 28, 19 49, *that I last saw the deceased alive on* Oct 28, 19 49, *and that death occurred at* 2 30 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Frey M. D. | 1428 Penna Ave | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 1, 1949 | Mt. Auburn Cem | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Mrs Kate R. Williams | 3201 Edmondson Ave |

VS 150

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G79406

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79406

1. NAME OF DECEASED (Type or Print): CHARLES JONES

2. DATE OF DEATH: October 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-01
D. STREET ADDRESS (If rural, give location): 823 W. Saratoga Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | married | June 26, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| laborer | | Balto. Md | U.S.A. |

13. FATHER'S NAME: Louis Jones

14. MOTHER'S MAIDEN NAME: Kistel Snownden

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W.I | | Beatrice Jones | 823 W. Saratoga St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Syphilitic Cardio Vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Oct. 28, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 1, 1949 | Balto. National | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs Katie R. Williams

ADDRESS: 322 N Schroeder St

VS 151

30E

G79407 BALTIMORE CITY HEALTH DEPARTMENT G79407

BIRTH NO. 49-09438 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Michael Andrew Maggio A72375 2. DATE OF DEATH OCT 30 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital Balto:Md.
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-06
D. STREET ADDRESS (If rural, give location) 1640 N. Wolfe, St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | S. | 5-8-49 | | 5 | 22 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Stephen Maggio
14. MOTHER'S MAIDEN NAME Marie Brewer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(A) Thrombosis, sup. long sinus
Subarachnoid hemorrhage.
DUE TO Congenital heart disease; single ventricle with pulmonary atresia.
(B)
DUE TO Thrombosis of pulmonary arteries.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17- 1949, *to* 10-30- 1949, *that I last saw the deceased alive on* 10-30- 1949, *and that death occurred at* 3:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE W. W. Maguire M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 10-30-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 1st, 1949 | Holy Redeemer Cemetery | Belair Rd. Balto:Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Timmington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: George J. Ruth, Inc. 1735 Harford Avenue, Balto:Md.

157E

G79408

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79408

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Jacob Timanus

2. DATE OF DEATH: October 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Convalescent Home
3604 Mohawk Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug, 5, 1874 | 75 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Zoning Commissioner,
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Co.

11. BIRTHPLACE (State or foreign country): Woodlawn, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Luther Timanus

14. MOTHER'S MAIDEN NAME: Mary George

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Horace J. Kindsor — ADDRESS: 7007 Windsor Mill Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 2yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-Sclerosis & Hypertension — DUE TO — unk.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 5, 19 49 *to* Oct 27, 19 49, *that I last saw the deceased alive on* Oct 29, 19 49 *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | Allegheny Ave., Towson | 10/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Oct. 31, 1949 | Mt. Olive Cemetery | Randallstown, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949

REGISTRAR'S SIGNATURE: [signature] Registrar, Md.

25. FUNERAL DIRECTOR: [signature] — ADDRESS: 4510 Liberty Hgts. Ave.

VS 150

93D

G79408 Dr. Hollies 3816 W North Ave G79408

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James Stokes — 2. DATE OF DEATH 10/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Penitentiary Hospital
C. Length of stay in Baltimore: 7 Yrs. 10 Mos. 18 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Virginia — B. COUNTY Prince Edward
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Green Bay
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | black | Married | 4/30/16 | 33 | 5 | 18 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| laborer | steel mill | Virginia | U.S. |

13. FATHER'S NAME Grant Stokes
14. MOTHER'S MAIDEN NAME Annie Street

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| UNKNOWN | | | |

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningitis
DUE TO
(B) Tuberculous Osteomyelitis
DUE TO
(C) Prob. Pulmonary tuberculosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1948 *to* 10-28-1949, *that I last saw the deceased alive on* 10-28-1949, *and that death occurred at* 8 p m., *from the causes and on the date stated above.*

23A. SIGNATURE Henry W. D. Hollies M. D. — 23B. ADDRESS 3308 W. North Ave. — 23C. DATE SIGNED 10-31-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Shipped | 10-31-49 | Green Bay | Virginia Va |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949 — REGISTRAR'S SIGNATURE: Lovington Williams, MD

25. FUNERAL DIRECTOR — ADDRESS
Rayner Sanders
1412 E. Preston St 13B

VS 150

G79410 ✓ G79410

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print): Virginia Stanton

2. DATE OF DEATH: Oct. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: 25 Yrs. 4 Mos. 0 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 1903 Sapp St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | 3/15/1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Virginia | |

13. FATHER'S NAME: Harrison Logan

14. MOTHER'S MAIDEN NAME: Army ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Harrison Stanton | 1619 Dallas St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemorrhage | 2 hours |
| | DUE TO Cerebral and generalized arterio-sclerosis | 2 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| B S Fisher M.D. | | Oct. 29, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-1-49 | Mt Calvary Cem A. A. Co | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | Rayner Sanders | 83a 1412 E Preston St |

VS 151

G79411

BIRTH NO. 49-09679

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79411

Registered No.

1. NAME OF DECEASED (Type or Print): David Battle

2. DATE OF DEATH: Oct 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills
D. STREET ADDRESS (If rural, give location): Featherbed Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Child | 4-24-49 | | 6 | 10 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Howard Harrison
14. MOTHER'S MAIDEN NAME: Madeana Battle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis rt. lower lobe
DUE TO Bronchopneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Multiple congenital deformities: cranistenosis, ? st. cleft lip
DUE TO
(C) left inguinal hernia, hypospadias, syndactylism

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: Tracheotomy
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-12-, 1949 *to* 10-30-, 1949, *that I last saw the deceased alive on* 10-30, 1949 *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: William W. Mabry, M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 10-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Oct 31-49
24C. NAME OF CEMETERY OR CREMATORY: Johnsville Cem.
24D. LOCATION (City, town, or county) (State): Carroll Co

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. F. Flinn
ADDRESS: Sons Reisterstown Md

157M

G79412

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79412 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George B. James

2. DATE OF DEATH: October 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Edgewood R.D.
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Dec. 9, 1872 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supt. | Road Work | Harford Co Md | U.S.A. |

13. FATHER'S NAME: George B. James

14. MOTHER'S MAIDEN NAME: Emma Keithly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Gilbert James Aberdeen Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis — DUE TO

(B) probably gall bladder — DUE TO

(C) Bronchopneumonia — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| INTERVAL BETWEEN ONSET AND DEATH |
|---|
| Oct - 24 |
| Oct - 29 |
| 5 days |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-28-49 | Carcinomatosis | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Oct 24, 1949 to Oct 29, 1949 that I last saw the deceased alive on Oct 29, 1949 and that death occurred at [illegible] m. from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Michael Hamandi M.D. | Aberdeen Md | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 4 1949 | Cokesbury | Abingdon Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| OCT 31 1949 | Washington Williams M.D. | Howard E. McComas & Son |

VS 150

46F Abingdon, Md.

CERTIFICATE CORRECTED ✓ 11-8-49 X

G79413 G79413

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 491

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOHN E. ~~MILES~~ MYLES

2. DATE OF DEATH: OCT. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: ~~Prince George~~ Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Harwood
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Married | | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | | Washington, D. C. | |

13. FATHER'S NAME: Francis Myles

14. MOTHER'S MAIDEN NAME: Virgie Stewart

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mrs. Helen Myles (wife) ADDRESS: Harwood, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| M.D. | | Oct. 31, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | Lincoln Mem. | Suitland, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949

REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.

25. FUNERAL DIRECTOR: Chas R. Law ADDRESS: 802 Madison Ave 107 Balto. 1, Md

VS 151

G7941 BALTIMORE CITY HEALTH DEPARTMENT E81.4 G7941
# CERTIFICATE OF DEATH
BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Louise Elmore N-903.4
2. DATE OF DEATH: Oct. 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Mercy Hospital
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-02
D. STREET ADDRESS (If rural, give location): 265. N. Exeter St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | March 6 1927 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Maryland | U.S.A. |

13. FATHER'S NAME: William Elmore
14. MOTHER'S MAIDEN NAME: Augusta ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Augusta Elmore - 265 N. Exeter St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Street | Orleans and Forrest St. 5-2 |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ | NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| Oct. 30, 1949 12:15 A.M. | | | Pedestrian, into side of auto, thrown to street and run over by second auto |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Carl L. Voigt M.D. | | 2 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | Mt. Calvary Cemet. | Cedar Hill Md. |

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: [illegible] for Nathaniu, M.D.
25. FUNERAL DIRECTOR ADDRESS: A. Halstead - 918 Druid Hill Ave

VS 151

170c

NS—125269 G79415

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

BIRTH NO. G79415 Registered No.

1. NAME OF DECEASED (Type or Print): Harry Smith

2. DATE OF DEATH: 10-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 5-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1212 St. Matthew St.

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11/23/1885
9. AGE (In years last birthday): 63 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper
10B. KIND OF BUSINESS OR INDUSTRY: Butter & Egg
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Smith
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records—Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemmorhage | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Hypertensive cardio vascular disease | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | DUE TO (C) | |

19A. DATE OF OPERATION: 5-19-49 12-22-48 5-9-49 5-6-49
19B. MAJOR FINDINGS OF OPERATION: Hemmorhoidectonmy (5-9-49)
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-11- , 1948, *to* 10-30- , 1949 *that I last saw the deceased alive on* 10-30- 1949, *and that death occurred at* 2 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: T. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 10-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 2-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn a. a. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 31 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Leroy D. Wilson ADDRESS: 1144 Brantley St

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 153

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith Delores Roth

2. DATE OF DEATH: Oct 31 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 221 E.North Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 221 E.North Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | July 8 1890 | 59 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Chamberlin Co. | Washington Co Md | |

13. FATHER'S NAME: Abraham Roth

14. MOTHER'S MAIDEN NAME: Amanda Grosh

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 141-01-9149 | Lewis A.Roth | 4209 Penhurst Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma (adenocarcinoma of colon)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 1949 | Carcinoma | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* — , 19[illegible], *to* Oct. 31 , 1949 *that I last saw the deceased alive on* Oct. 29, 1949, *and that death occurred at* 7 a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward Horan M. D. | 101 W Read St. | 10.31.49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 2 1949 | Druid Ridge | Pikesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | [illegible] M.D. | Harry A Thomas | 4204 Ridgewood Ave |

VS 150

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-20366 Registered No.

1. NAME OF DECEASED (Type or Print): Johnnie Mae Ross
2. DATE OF DEATH: 9-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: 22hrs

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 106 N Gilmor St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Negro | N.B. | 9-24-49 | | | | 22 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md. | US |

13. FATHER'S NAME: John Ross
14. MOTHER'S MAIDEN NAME: Esther Mae Cosby

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | 106 N. Gilmor St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6½ hrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/24, 1949 *to* 9/25, 1949 *that I last saw the deceased alive on* 9/24, 1949 *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Washington Jr. M. D. | 1553 W. Lafayette Ave | 9/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Cremated in Washington | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| OCT 31 1949 | Huntington Williams, M.D. | | |

VS 150

160a

G79418 CERTIFICATE CORRECTED 11/4/49 ✓155 G79418

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Herbold GERHOLD, CHRISTIANA M.

2. DATE OF DEATH 10/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 6504 Fairdel Ave 27-05

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 2/11/1876 | 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Anton Stecher
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Geo. N. Gerhold ADDRESS 3104 Chesterfield Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxemia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Generalized peritonitis
DUE TO
(C) Ruptured Gall Bladder
Carcinomatosis gall bladder into liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/22 1949 to 10/30 1949, *that I last saw the deceased alive on* 10/30 1949, *and that death occurred at* 11:30 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE L. Leonard Dessau M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 10/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11/3/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~ Parkwood
24D. LOCATION (City, town, or county) (State) Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

46F

G79418 **CERTIFICATE CORRECTED** 11-26-49 G79418

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): EMMA RICHMON ~~RICHTON~~ Mrs. 1 — 2. DATE OF DEATH: 10/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16 15-06
D. STREET ADDRESS (If rural, give location): 2541 W. Nathan.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | Oct. 29, 1880 | 69 6-2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Hw. | Md. | |

13. FATHER'S NAME: [illegible] Hoy
14. MOTHER'S MAIDEN NAME: Sarah Seaborn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Husband. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Hypertension — DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B) Cardiac Failure — DUE TO

(C) Coronary Occlusion

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/27 1949 *to* 10/29 1949, *that I last saw the deceased alive on* 10/29 1949 *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nicholas Mallis M. D. | Univ. Hosp. | 10/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/1/49 | Mt Olivet | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Wilhorn & Son | 1219 Park Ave |

VS 150

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G79420

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G79420

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kati E. Ruppert

2. DATE OF DEATH: Oct. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4614 Mainfeild Ave

c. Length of stay in Baltimore: 18 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4614 Mainfeild Ave. 27-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1-18-1889 | 60 | 9 : 16 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife at Home | | Germany | USA |

13. FATHER'S NAME: Philip Young

14. MOTHER'S MAIDEN NAME: ~~Not Known~~ Kati Schuler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | None | Mr. R. J. Ruppert | 4614 Mainfeild Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 15 minutes |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Angina pectoris | 3 yrs. |
| DUE TO | | |
| (C) | Arteriosclerosis | ? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug. , 1946 *to* 29 Oct, 1949, *that I last saw the deceased alive on* 29 Oct. 1949, *and that death occurred at* 3:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Silverfield M. D. | 712 E. Preston St. | 31 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-1-49 | Most Holy Redeemer Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Elmer W. Conkling | 924 E. Eager St. |

VS 150

94a

G79421

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E900.0 G79421

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Walter SAWICKI (Last) — N-853.0

2. DATE OF DEATH: Oct. 31, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 817 S. Montford Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 817 Montford Ave. S. — 1-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | Nov. 28, 1916 | 32 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Balto., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Nicholas Sawicki | Mary A. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | None | Mary A. 817 S. Montford Ave. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hemorrhage, with compression and contusion of brain.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) (over)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fatty degeneration of liver.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 817 S. Montford Ave. 1/4 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Oct. 31, 1949 ? m. | | slipped and fell down steps |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Oct. 31, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov-3-49 | Sacred Heart of Mary | Gernon Hill Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | J. A. Grebliunas Jr. 1905 E. Pratt St |

VS 151

186a

79422

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 1

G79422

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ISRAEL FELDSTEIN

2. DATE OF DEATH: 10-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 826 N. Broadway 7-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber - Ret. | | Russia | U.S.A. |

13. FATHER'S NAME: Yankov

14. MOTHER'S MAIDEN NAME: Chia

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Sarah Feldstein | 826 N Bdwy |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis — 10 months

DUE TO

(C) Arteriosclerosis — unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 20, 1948, *to* Oct 5, 1949, *that I last saw the deceased alive on* Oct 5, 1949, *and that death occurred at* 12 noon *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Hurd D Halin M. D. | 1823 Park Avenue (17) | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-1-49 | Hebrew Young Men | Balto. MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Jack Lewis Inc. | 2100 Eutaw Place |

VS 150

61

G79423

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

51

G79423

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Philip Kessel

2. DATE OF DEATH 10/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2419 Keyworth Ave 15-12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| M | W | M | | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CARPENTER | | Russia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ABRAHAM | NOT KNOWN |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | ABE RABINOWITZ | 2419 KEYWORTH AVE |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/30, 19 49 *to* 10/30, 19 49, *that I last saw the deceased alive on* 10/30, 19 49, *and that death occurred at* 8 10 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Mag Miller M. D. | Sinai Hospital | 10/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-1-49 | NORTH B. + GERMAN HILL RD | BALTO MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | JACK LEWIS INC | 2100 EUTAW PL |

VS 150

46B

G79424

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79424

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN PEAFF

2. DATE OF DEATH: 10/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 5100 RICHARDS AVE

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE MD B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ✓

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO 2-1-02

c. Length of stay in Baltimore: 67 Yrs. 11 Mos. 4 Days

D. STREET ADDRESS (If rural, give location): 1172 NANTICOKE ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, (Divorced or Widowed) (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | W | WIDOWER | NOV 27 1861 | 87 | 11 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never say "retired") | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LAWYER | WOOD WORKER | BALTO | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| NOT KNOWN | NOT KNOWN |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 219-07-3395 | MRS HANNETIE ADAMS | 5100 RICHARDS Rd |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-3 Months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1949 *to* 10/31/, 1949 *that I last saw the deceased alive on* Oct 31, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rebecca Hollen M. D. | 5703 Harford Rd | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 11/3/49 | LOUDON PK | FREDERICK AVE |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Geo. H. Lernbuch & Son | 1 N. Fulton Ave |

VS 150

94a

G79425

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79425 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henrietta Russell

2. DATE OF DEATH: Oct 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3618 Hamilton

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-34
D. STREET ADDRESS (If rural, give location): 3618 Hamilton Ave

c. Length of stay in Baltimore: Yrs. Life; Mos.; Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Sept 9 1874
9. AGE (In years last birthday): 75 (If under 1 year: Months; Days; If under 24 hours: Hours; Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Foos
14. MOTHER'S MAIDEN NAME: Ann Peregoy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Theo Lingenfelder ADDRESS: 3618 Hamilton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) Acute Cholecystitis — 7 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 27, 1949 *to* Oct 29, 1949, *that I last saw the deceased alive on* Oct 28, 1949 *and that death occurred at* 7 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: George Sawyer M. D.
23B. ADDRESS: 4808 Harford Rd.
23C. DATE SIGNED: 10/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 1/49
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem
24D. LOCATION (City, town, or county) (State): Balto

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Welsh Funeral Home ADDRESS: 2008 Eden

VS 150

93D

G79426

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

G79426

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary W Le Brun

2. DATE OF DEATH: Oct 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 413 S Lehigh 26-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | widow | Oct 26 1865 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm J Boston | Eliza Cole |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Robert Kirkwood | 413 S Lehigh |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 15 Mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan, 1949, *to* Oct 29, 1949, *that I last saw the deceased alive on* Oct 29, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C R Evans M. D. | 1 Liberty Parkway | Oct 29 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 2/49 | Meadow Ridge | Dorsey Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Ulrich Funeral Home | 2058 Orleans |

VS 150

46 B

G79427

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 9.9.8

G79427

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): FRANK MONTE N-861.4

2. DATE OF DEATH: October 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 12 W. Randall Street 23-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | single | Jan. 9, 1926 | 23 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | U.S. Army | Balto. Md. | |

13. FATHER'S NAME: Louis Monte

14. MOTHER'S MAIDEN NAME: Cornelia Castagneti

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| yes World War II | | Louis Ponte 12 N. Randall St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of Heart

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public | Stoney Creek Road — 2 mi. S. of Ferndale River |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10-30-49 ? a.m. | | Firearms |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl M. Young M.D. | [ ] [ ] [ ] | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2/49 | Baltimore National | Frederick Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | KRAUSE FUNERAL HOME 1216 S. Charles St. |

VS 151

184

G79428

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

163 Registered No. G79428

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry G. Hyser

2. DATE OF DEATH: Oct. 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. 1409 Webster St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE 1409 Webster St. — B. COUNTY Balto.30Md.

6. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 24-c

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): Maryland

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | Oct. 3,1903 | 46yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| salesman | Automobiles | Balto. Md. | |

13. FATHER'S NAME: Harry M. Hyser

14. MOTHER'S MAIDEN NAME: Mary Rebstock

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| no | 214-09-7219 | Freda Hyser 1409 Webster St. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Haemoptysis

DUE TO

(B) Carcinoma R. Lung

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1949 to Oct 29, 1949 *that I last saw the deceased alive on* Oct 20, 1949 *and that death occurred at* 7:11 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jas. Jno. C. Gratz M. D. | 1 E Randall St Balto 2 | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) ADDRESS |
|---|---|---|---|
| Burial | Nov. 2/49 | Holy Cross Cemetery | Ritchie Highway |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: KRAUSE FUNERAL HOME 1216 S. Charles St

VS 150

471

G79429

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

Registered No. G79429

1. NAME OF DECEASED (Type or Print): Irene I Baker

2. DATE OF DEATH: 10-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Upland Apts Edmondson Village

c. Length of stay in Baltimore: 4625 Edmondson Ave — Yrs. 28 Mos. 10 Days 04

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 4625 EDMONDSON Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Divorced | 1-5-1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| OBLIGATION OFFICER | FORT Meade | Mich | |

13. FATHER'S NAME: Louis I. Price

14. MOTHER'S MAIDEN NAME: Ella M. Robbins

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Alfred A. Baker | 518 Chestnut Hill Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, Hypertension

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| M.D. | ☐ ☐ ☐ | 11-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-2-49 | Woodlawn | Baltimore Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | John A. Moran | 3000 E. Balto. St. |

VS 151

83a

APPROVED BY CHIEF MEDICAL EXAMINER

CERTIFICATE CORRECTED 11-1-49

G79430

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 451

BIRTH NO. G79430 Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): WILLIAM TEMPLE GEPHART | 2. DATE OF DEATH: October 30, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore |
| c. Length of stay in Baltimore: ? Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location): 3201 N. Calvert St. 12-07 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | ~~xxxxxx~~ 3/26/87 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Major - U. S. Army | Cumberland, Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Temple D. ~~Templeton G.~~ Gephart | Cora Wickert |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| Yes VA 2 (World War 2) | ? | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Dissecting aneurysm of aorta, | ? 5 min. |
| DUE TO | ruptured (immediately prior to death) | |
| ANTECEDENT CAUSES. (B) | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | CERTIFICATION APPROVED BY Wm. H. Kammer, M.D. per P.B. Fisher M. D. | |
| (C) | CHIEF OR ASST. MEDICAL EXAMINER. | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* DEAD ON ARRIVAL, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 7:30P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Ray Howard-, Surgeon M. D. | US Marine Hospital, Balto, Md. | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Balto. National Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

301

G79431

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1949-8 Registered No. G79431

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary I. Eichman

2. DATE OF DEATH 10/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore (a)

D. STREET ADDRESS (If rural, give location) 2839 Calvert Street 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Feb. 12, 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Cassidy

14. MOTHER'S MAIDEN NAME Elizabeth -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no

17. INFORMANT Mrs. Chase ADDRESS 800 Cathedral St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH 5 days

DUE TO

(B) Carcinomatosis (over) — 2 mo.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/27, 1949, *to* 10/29, 1949 *that I last saw the deceased alive on* 10/29, 1949, *and that death occurred at* 1:50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE M. D.

23B. ADDRESS 1213 Light Street

23C. DATE SIGNED 10/29/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Loudon Park Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

Dr. FORMAN

46E

G79432

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79432

1. NAME OF DECEASED (Type or Print): JOHANA CLAZEY.

2. DATE OF DEATH: October 29-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 706-McCabe Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 706-Mc Cabe Ave 27-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married. | June 7-1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife. | Own Home | Baltimore - Md. | U.S.A. |

13. FATHER'S NAME: George Sauers.

14. MOTHER'S MAIDEN NAME: Fredericka Ilsman.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | No. | | George W. Clazey | 706-Mc Cabe Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerotic C.-V. Disease — 6 m

DUE TO

(C) Partial Intestinal Obstruction — 2 days

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 25 1949 *to* Oct. 29, 1949, *that I last saw the deceased alive on* Oct. 29, 1949, *and that death occurred at* 7 A.M. P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Carl H. Jensen, M.D. M. D., | 5111 York Rd. | Oct-31, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Nov. 1-1949. | Loudon Park Cemetery. | Baltimore - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Beatrice Von Williams, M.D. | Charles J. Schwab. | 3512 Frederick Ave |

VS 150

93D

G79433

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

50.0

G79433

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): ALVERDA - MATTHEWS.

2. DATE OF DEATH: October 30-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 905 Wilmington Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 2120 W. Fairmont Ave. 20 - 02

c. Length of stay in Baltimore: 70 yrs. (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed. | April-25-1859 | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife. | Own Home. | Davidsonville - AA. Co. Md. | U. S. A. |

13. FATHER'S NAME: Thomas Knighton.

14. MOTHER'S MAIDEN NAME: Ellen Ruth Lee

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no. | None | Mrs. Agnes Parker | 2120 W. Fairmont Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Arteriosclerosis — ?

DUE TO

(C) Senility — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 10/11, 1949 to 10/30, 1949 that I last saw the deceased alive on 10/28, 1949, and that death occurred at 12:15 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Williamson" M. D. | 3325 Frederick Ave | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Nov. 3-1949. | Loudon Park Cemetery. | Baltimore - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Charles J. Schwab | 3512 Frederick Ave. |

VS 150

97

G79434

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79434

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEROY SHEPARD

2. DATE OF DEATH: October 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 611 S. Fremont Ave. 22-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | col | Div. | 5/24/87 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Va. | USA |

13. FATHER'S NAME: David Shepard

14. MOTHER'S MAIDEN NAME: Mary Pitt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Va I | 218-05-1207 | Records - US Marine Hospital | Balto. Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Nephritis, acute, with uremia | 1 wk. |
| DUE TO (B) | Adenocarcinoma of prostate | Unknown |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Pyloric stenosis due to scarring of duodenum | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Oct. 5, 1949, *to* Oct. 30, 1949, *that I last saw the deceased alive on* Oct. 30, 1949, *and that death occurred at* 2:35P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-3-49 | Shoulder Hill Cem. | Suffolk, Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Mrs Frances A. Hemsley | 578 N. Biddle St. |

VS 150

513

9435

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79435

BIRTH NO. 49-23207

1. NAME OF DECEASED (Type or Print): BABY BOY INGLE "A"

2. DATE OF DEATH: Oct. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.

c. Length of stay in Baltimore: 3 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Belair Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 28, 1949 | | | 3 | 6 | 50 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant.

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Ralph Ingle

14. MOTHER'S MAIDEN NAME: Geraldine Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mother ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial Hemorrhage
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
atelectasis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 28 1949 *to* Oct. 31, 1949, *that I last saw the deceased alive on* Oct. 31, 1949, *and that death occurred at* 10 35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Benjamin Ambrose M. D.

23B. ADDRESS: Franklin Square Hospital

23C. DATE SIGNED: Nov. 1 '49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 3, 1949

24C. NAME OF CEMETERY OR CREMATORY: Powells Valley

24D. LOCATION (City, town, or county) (State): Towson, Claiborne Tenn.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Berryman ADDRESS: Dundalk Riververtown

VS 150

160a

G79436

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79436

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James L. McLaughlin

2. DATE OF DEATH: Oct. 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 831 Chapel Gate Lane

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 831 Chapel Gate Lane 28-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Sept. 5, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Electrician | B. & O. R. R. | Balto. Md. | |

13. FATHER'S NAME: James McLaughlin

14. MOTHER'S MAIDEN NAME: Mary A. Schmidt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 705 05 8699 | Mrs. Katherine M. Wallace, (Sister) | 831 Chapel Gate Lane |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fung abscess + Ch. nephritis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept, 1946 *to* Oct 29 1949, *that I last saw the deceased alive on* Oct 24, 1949 *and that death occurred at* 3:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. H. Callard M.D. M. D. | 332 Frederick Ave | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2/49 | Meadow Ridge Memorial Park, | Dorsey, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Harry R. Nitzke | 4101 Edmondson Ave. |

VS 150

1316

G79437

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79437

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas L Finnerty

2. DATE OF DEATH: Oct. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1345 S. Clinton St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1345 S. Clinton St. 2-6 06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 21, 1893 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | | Baltimore | |

13. FATHER'S NAME: Michael Finnerty

14. MOTHER'S MAIDEN NAME: Margaret Dunnigan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Charlotte P. Finnerty | 1345 S. Clinton |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchiogenic Carcinoma | 9 mo. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 1949 | Inoperable Bronchiogenic Carcinoma | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1949 *to* October 1949, *that I last saw the deceased alive on* Oct. 30 1949, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clarence W. LeDoux M. D. | 3023 Eastern Ave | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Oak Lawn Cemetery | 7225 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Clarence F. Hoffmann | 1639 Broadway |

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X

G79438

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79438

G79438 BIRTH NO.

1. NAME OF DECEASED (Type or Print): August Thery

2. DATE OF DEATH: 10-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 32 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7349 Waldman Ave. Z-19

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Mar. 16, 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Belgium

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? ? ?

14. MOTHER'S MAIDEN NAME: Mary Thery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Records-- ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage from the Gastro-intestinal tract — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Esophageal varices- cirrhosis of Liver

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-19-49 | Gastro intestinal bleeding | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-17- , 1949, *to* 10-31- , 1949 *that I last saw the deceased alive on* 10-31- 1949, *and that death occurred at* 3:10 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. D. Ziegler M. D. | Baltimore City Hospitals | 1 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Nov 3rd 1949 | Greenmount | Oliver St Greenmount Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams M.D. | Leo Lesch | 1703 N Patterson Park Ave |

VS 150

1248

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 977.8 G79438 — Registered No. G79439 — BIRTH NO. G79439

N-874

1. NAME OF DECEASED (Type or Print): Lucy Ellen Armstead
2. DATE OF DEATH: Oct. 31, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1216 N. Eden St. 10-01
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Seperated
8. DATE OF BIRTH: Jan. 19, 1914
9. AGE (In years last birthday): 35 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Rudy Bell.
14. MOTHER'S MAIDEN NAME: Ortelia Maddox
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT, ADDRESS: Ortelia Brown 1216 N. Eden St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Severed Rt. Jugular vein

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found under the bridge at Fallsway & Chase
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 31, 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Sharp Instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Emil L. Pope M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Oct. 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 3/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Park
24D. LOCATION (City, town, or county) (State): Arbutus Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Robert A. Elliott Daughter
ADDRESS: 1641 1129 N. Carlton St.

VS 151

G79440

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79440 Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Leo Grover Malone

2. DATE OF DEATH: October 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 16 S. Potomac St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 16 S. Potomac Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 2, 1865 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Ship Caulker | Arundel Corp. | Baltimore, Maryland | |

13. FATHER'S NAME: FRANCIS

14. MOTHER'S MAIDEN NAME: MARY

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 214-03-0174 | Mrs. Clara Malone | 16 S. Potomac S |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis

DUE TO

(B) Arterisclerosis and hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/29/ , 1949, *to* 10/31/ , 1949, *that I last saw the deceased alive on* 10/31/ , 1949, *and that death occurred at* 7:00 AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Siwinski M. D. | 1400 N. Caroline Street | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 11/3/49 | Moreland Mem. | Taylor Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | L. Heemann and Son | 6067 Harford rd |

VS 150

S 3 B

G79441

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79441

1. NAME OF DECEASED (Type or Print): Beatrice Butler

2. DATE OF DEATH: 10/29/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1825 Orlean Street
C. Length of stay in Baltimore: 9 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1825 Orlean Street 6-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | 10/10/1917 | 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work during working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Way Cross Ga | U.S.A. |

13. FATHER'S NAME: Rev J. F. Harrell

14. MOTHER'S MAIDEN NAME: Cassie Wilcox

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | William M. Butler I825 Orlean Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/12 1949, to 10/29 1949, *that I last saw the deceased alive on* 10/29 1949, *and that death occurred at* 3:40 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert L Lofford M. D. | 8221 Belmont Ave | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II/1/1949 | Mt Calvery Cem. | Brooklyn A.A.Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR / ADDRESS: Elroy O. Wilson 1000 Brantly Ave.

VS 150

13B

G79442

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

170 Registered No.

G79442

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ADA FITZGERALD

2. DATE OF DEATH November 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1222 East Chase Street 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 1 day: Hours / Min. |
|---|---|---|---|---|---|---|
| female | Colored | widowed | 1-27-1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Virginia | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Betty Foster

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Wm. Fitzgerald | 1405 Ashland Avenue |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the breast with necrosis and hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. H. Fraser M.D | | Nov. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| removal | 11-1-49 | | Crew, Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Geo. G. Kelson | 1303 Presstman Street |

VS 151

50

MS—1 (Orig) 79443 — 67-9443

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Bennie Blackwell

2. DATE OF DEATH: 10-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 26 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1111 Warner St. 71-01

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb. 28, 1906
9. AGE (In years last birthday): 43 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thad Blackwell

14. MOTHER'S MAIDEN NAME: Alice Blackwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-03-8733

17. INFORMANT: Records—Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchogenic carcinoma of R.U.L.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-16- , 1949 *to* 10-29- , 1949, *that I last saw the deceased alive on* 10-29- 1949, *and that death occurred at* 5:50 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 10/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: November Forty
24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore City Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph A. Lisby ADDRESS: 661 West Baltimore Street

VS 150

47c

BIRTH NO. 22649

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 67944

1. NAME OF DECEASED (Type or Print): Sophia Debus (DeBus)
2. DATE OF DEATH: 10/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland. 1446 S. Charles St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1446 S. Charles St
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 23-01
D. STREET ADDRESS (If rural, give location): 1446 S. Charles St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W Wh | Married | Aug 26 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Balto | U.S. |

13. FATHER'S NAME: James Hutton
14. MOTHER'S MAIDEN NAME: Sophie Voyce

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | John Debus | 1446 S. Charles |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| C. P. Sulzinski M.D. | | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 3, 1949 | Balto National | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | A. Howard Evans & Son | 1446 S. Charles |

VS 151

94a

G79445

G79445

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 20.0

1. NAME OF DECEASED (Type or Print): HARRISON BURKE GOSNELL

2. DATE OF DEATH: OCT 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3031 CHESLEY AVE

C. Length of stay in Baltimore: LIFE (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO, MD.
D. STREET ADDRESS (If rural, give location): 3031 CHESLEY AVE 27-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | OCT 24, 1880 | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GARMENT CUTTER,
10B. KIND OF BUSINESS OR INDUSTRY: UNDERWEAR MFG.
11. BIRTHPLACE (State or foreign country): BALTO
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: JOSEPH GOSNELL
14. MOTHER'S MAIDEN NAME: CATHERINE GORMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: BLANCHE GOSNELL ADDRESS: 3031 Chesley

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Multiple Encephalomalacia | 6 days |
| DUE TO | BULBAR PARALYSIS | 3 days |
| | CEREBRAL ARTERIOSCLEROSIS | 1½ YEARS |
| (B) DUE TO | arteriosclerotic Heart Dis. | 3 YRS |
| (C) | Generalized ARTERIOSCL. | 3 YRS |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 26, 1947 *to* Oct 31, 1949 *that I last saw the deceased alive on* Oct 30, 1949, *and that death occurred at* 8.20 PM *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Hirschfeld M. D.
23B. ADDRESS: 6919 HARFORD Rd
23C. DATE SIGNED: 11/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/3/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Parkwood
24D. LOCATION (City, town, or county) (State): Taylor Ave

DEATH RECEIVED BY LOCAL REGISTRAR: NOV 1 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Medford J. Blight ADDRESS: 6009 Harford Rd

VS 150

82

CERTIFICATE CORRECTED 11-7-49 X ✓ G75448

G79446

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E816.1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELLIS ~~GIDDON~~ Jackson GIDEON N-805.0

2. DATE OF DEATH: October 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marine Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore County
D. STREET ADDRESS (If rural, give location): Falls Road, Brooklynville

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 23, 1924 | 25 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Bleach Mill | Missouri | USA |

13. FATHER'S NAME: William Andrew ~~Gidden~~ Gideon

14. MOTHER'S MAIDEN NAME: Florence Russell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| Yes | World War II | |

17. INFORMANT: Mrs. Mary ~~Gidden~~ Gideon — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fractured neck | |
| DUE TO | and ribs | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): York Rd., ¼ mile north of Towson, Balto. Co., Md.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: October 30, 1949 approx. 6:20p.m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK X

21F. HOW DID INJURY OCCUR? Auto into "horse van"

22. *I certify that I took charge of the remains described above, held an* Autopsy (partial) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry) — Partial

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER X MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Oct. 31, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov. 1, 1949 | Tatum Funeral Home | Anderson, Missouri |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR — ADDRESS: John Burns' Sons, Towson, Md.

VS 151

170c

G79147 ✓ G79147

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martha Emma Bree — 2. DATE OF DEATH: 10/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 812 W. Monroe St.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04 — D. STREET ADDRESS (If rural, give location): 812 W. Monroe St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widowed | 2/24/1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife — 10B. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Balto. Md. — 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Brown — 14. MOTHER'S MAIDEN NAME: Jane Slymer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT: Mildred Henson — ADDRESS: 812 W. Monroe St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio-renal Disease — INTERVAL BETWEEN ONSET AND DEATH: Sev. yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 6-4, 1949 *to* 10/29, 1949 *that I last saw the deceased alive on* 10/26, 1949, *and that death occurred at* 6:50 P.M. *from the causes and on the date stated above.*

BRENNER BROS. FUNERAL HOME, 1300 EAST MADISON ST., BALTIMORE, MD.

23A. SIGNATURE: [signature] — 23B. ADDRESS — 23C. DATE SIGNED: 11-1-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Mt. Calvary | G. G. County Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949 — REGISTRAR'S SIGNATURE: [signature] — 25. FUNERAL DIRECTOR: Robert L. Young — ADDRESS: 1532 E. Monument St

VS 150

131a

679148 ✓ 679148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Maria Reda

2. DATE OF DEATH: Oct. 30 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 3223 Ravenwood Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 23 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. State: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3223 Ravenwood Ave 8-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | March 5 1862 | 87 | 7 | 25 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Mendicino Italy | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Eugene Reda | 3223 Ravenwood Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis

DUE TO

(B) Arterio Sclerosis

DUE TO

(C) Fibrosis of Lungs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 19 49 *to* Oct 29 19 49, *that I last saw the deceased alive on* Oct 25 19 49, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Merrs A Fine M.D. | 18 Bisquick St | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | November 2 1949 | Holy Redeemer Cemetery | 4430 Belair Rd. Balt. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Frank Della Rose | 322 S. High St. |

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G79449

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79449

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS JEFFERSON

2. DATE OF DEATH: October 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 919 McCulloh Street 11-04

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: Jan. 4 1900
9. AGE (In years last birthday): 49 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter.
10B. KIND OF BUSINESS OR INDUSTRY: [illegible] Co. Club.
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. Thomas Jefferson
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

INFORMANT: [illegible] ADDRESS: [illegible]

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arterio-sclerotic C.V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* [illegible] *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 10-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/2/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemet.
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: A. Sabatead
ADDRESS: 918 Druid Hill Ave.

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G79450

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G79450

Registered No. E971-3

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES POWELL — N-979-9

2. DATE OF DEATH October 31, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 822 Hollins Street 18-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 1/9/1908 | 41 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Blacksmith | Coppers Co. | Wilmington Del. | U S A |

13. FATHER'S NAME Harry J. Powell

14. MOTHER'S MAIDEN NAME Catherine Sparks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) World War II

16. SOCIAL SECURITY NO.

17. INFORMANT Mr Harry J. Powell ADDRESS 822 Hollins St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia complicating — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Stricture of esophagus

DUE TO

(C) Ingestion of lye — Sept. 26, '49

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 822 Hollins St. |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21f. HOW DID INJURY OCoccur? |
|---|---|---|
| September 26, 1949 ? | | Ingestion of lye |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

| 23a. SIGNATURE | 23b. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR | 23c. DATE SIGNED |
|---|---|---|
| per Russell S Fisher George U. Merrill, M.D. M.D. | | Nov. 1, 1949 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | New Baltimore Nath | 5501 Frederick Ave |

DATE RECEIVED BY LOCAL REGISTRAR NOV 1 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR John J. Cowan & Son ADDRESS 1639 W. Baltimore St.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 447 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nevada Eakle

2. DATE OF DEATH: 11-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. / Mos. / Days: 1 da

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elkridge Md.
D. STREET ADDRESS (If rural, give location): 5608 Main St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 11/14/1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House work | at Home | Elkridge Md | USA |

13. FATHER'S NAME: William H. Hastings

14. MOTHER'S MAIDEN NAME: Ella Lineberger

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | William E. Eakle | 5608 Main St. Elkridge Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage
DUE TO
(B) Intraventricular extension
DUE TO
(C) hypertensive disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ✓ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-31, 1949, to 11-1, 1949, *that I last saw the deceased alive on* 11-1, 1949, *and that death occurred at* 8:10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fred R. McCunn M. D. | University Hospital | 11-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | Meadowridge Memorial Park | Washington Blvd Dorsey |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | [illegible] | John J. Cowanston | 923 Baltimore St. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

754 6

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Horace Williams Jr. | 2. DATE OF DEATH: Nov. 1 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland [illegible] HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mo. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Texas | B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wichita Falls

D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 11-19-35 | 13 14 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Texas | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Horace Williams | Bonnie Evans |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cardiac failure | 2½ yrs. |
| DUE TO (B) | Pulmonary valvular stenosis | Congenital |
| DUE TO (C) | Pulmonary valvulotomy | 30 min. |

CERTIFICATION APPROVED BY

R F Loeb M. D.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/1/49 | Pulmonary stenosis | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? |
|---|---|---|
| | | [illegible] exact location) |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/17 1949 *to* 11/1 1949, *that I last saw the deceased alive on* 11/1 1949, *and that death occurred at* 12m *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard J Kaplan Jr. M.D. | JOHNS HOPKINS HOSPITAL | 11/1/49 |

| 24A. BURIAL, CREMATION, TRANSIT REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | | Wichita Falls Texas |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | John O. Mitchell Sons | 1900 Eutaw Place |

VS 150

Medical Ex Case To be approved 157E

State Anatomical G79453

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4 20.0 G79453

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Richardson

2. DATE OF DEATH: Oct. 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 270 N. Exeter St 5-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 10-5-93 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Handyman | | So. Carolina | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harry Richardson | Irene ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/18, 1949, *to* 10/24, 1949, *that I last saw the deceased alive on* 10/24, 1949, *and that death occurred at* 10 35 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip J. Wagley M. D. | JOHNS HOPKINS HOSPITAL | 10-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL OCT 31 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 1 1949 | Hunter for Williams, M.D. | Commissioner of Health |

VS 150

Correct Age if Especially Important. If Questionable, Put Question Mark.

111 93D

G79454
FA 132613

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

172 Registered No. G79454

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Lake.

2. DATE OF DEATH 10-17-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 540 S. Green ST. 22-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Widowed | July 6, 1882 | 67 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: John Lake.

14. MOTHER'S MAIDEN NAME: Amanda Cannon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Records B.C.H. | 4940 Eastern Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma Of Prostate with Bony Metastases

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-14, 19 49 *to* 10-17, 19 49 *that I last saw the deceased alive on* 10-17-, 19 49, *and that death occurred at* 2.30P M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. L. Mozen M. D. | 4940 Eastern Ave | 10-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | OCT 31 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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79455

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0-3

Registered No. 79455

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Lewis

2. DATE OF DEATH: 10-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals

c. Length of stay in Baltimore: 85 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): ( NO HOME) 26 - 1 Y

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Widowed | March 15, 1861 | 88 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | S.C. | |

13. FATHER'S NAME: Easton Lewis

14. MOTHER'S MAIDEN NAME: Millie ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| | | |

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cardiac Insufficiency | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) luetic Heart Disease | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis General | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-2, 1947, *to* 10-16, 1949, *that I last saw the deceased alive on* 10-16 1949, *and that death occurred at* 2:15 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Chozen M. D. | 4940 EASTERN AVENUE | 10- 25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | [illegible] OCT 31 19[illegible] | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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G79456

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79456 Registered No.

BIRTH NO. 49-22375

1. NAME OF DECEASED (Type or Print): Male infant Herndon

2. DATE OF DEATH: 10-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp
C. Length of stay in Baltimore: 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 911 Whaley Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | Single | 10-[illegible]-44 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | | U.S.A. |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Mae Herndon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxic dermatitis c secondary infection — INTERVAL BETWEEN ONSET AND DEATH: present at birth

DUE TO and

(B) Pulmonary infarctions — unknown

DUE TO Fibro cystic disease of pancreas — Pending microscopic results

(C) Etiology not determined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Dehydration

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-17-49, 19__, *to* 10-25, 1949 *that I last saw the deceased alive on* 10-25, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louisa Cadden M.D. | Maryland General Hospital | 10-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL OCT 31 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Commissioner of Health | |

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G79457

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79457

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Anna Lynch (Anna Lynch) 430.1

2. DATE OF DEATH Nov. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2805 Goodwood Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 2805 Goodwood Road 27-03

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2805 Goodwood Road

c. Length of stay in Baltimore 4 yrs 8 mos Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W White | Widowed | March 17, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housekeeper | | Ireland | |

13. FATHER'S NAME Patrick Connor

14. MOTHER'S MAIDEN NAME Maria Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Kathryn Hughes | 2805 Goodwood Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac & vascular collapse — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* after 1 m, 19 49 *to* Nov 1, 19 49 *that I last saw the deceased alive on* Sept 1, 19 49 *and that death occurred at* 11 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. E. Brown M. D. | 2136 Maryland Ave | Nov 4 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/1/49 | Holy Sepulcher | Philadelphia, Pennsylvania |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Evelyn Fox Williams M.D. | Wm. Cook, Inc., | 1217 St. Paul Street |

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G79458 G79458

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Frank E. Stevens
2. DATE OF DEATH: 10/31/49 10 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2519 Barclay st.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2519 Barclay St. 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 12/15/1867 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Farming | Rock Hall Md. | |

13. FATHER'S NAME: William Stevens
14. MOTHER'S MAIDEN NAME: Laura Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | David V. Stevens | 510 Hollen Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) ~~HYPERTENSION~~ CARDIO-VASCULAR ACCIDENT | 6 days |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) HYPERTENSION | sev yrs. |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 25, 1949, *to* Oct. 31, 1949, *that I last saw the deceased alive on* Oct. 30, 1949, *and that death occurred at* 10:55 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Ellsworth Poole M. D. | 2431 MARYLAND AVENUE | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Wesley Chapel | Rock Hall Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Wm Bok Inc. | 1217 St. Paul St. |

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79459 NT CERTIFICATE CORRECTED 11-10-49

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 193

Registered No. G79459

1. NAME OF DECEASED (Type or Print) Wenner, Calvin

2. DATE OF DEATH 11-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Virginia B. COUNTY Loudon

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Lovettsville

D STREET ADDRESS (If rural, give location) Rural, Weverton, Maryland

c. Length of stay in Baltimore 14 days (Yrs. Mos. Days)

5. SEX Male

6. COLOR OR RACE White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) Married

8. DATE OF BIRTH 7-27-1901

9. AGE (In years last birthday) 48 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman

10B. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.

11. BIRTHPLACE (State or foreign country) Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles H. Wenner

14. MOTHER'S MAIDEN NAME Annie E. Rickards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 705-07-7706

17 INFORMANT Mrs. Verna G. Wenner (wife) ADDRESS Weverton, Md. Rural

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intracranial hypertension Brain tumor

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION 9-29-49

19B. MAJOR FINDINGS OF OPERATION Ependymoma 4th ventricle

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17-49 *to* 11-1-49, *that I last saw the deceased alive on* 11-1-49, *and that death occurred at* 6:30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D.

23B. ADDRESS University Hosp

23C. DATE SIGNED 11-1-49

24A. BURIAL, CREMATION (Specify)

24B. DATE 11-4-49

24C. NAME OF CEMETERY OR CREMATORY Union

24D. LOCATION (City, town, or county) (State) Lovettsville Va.

DATE RECEIVED BY REGISTRAR NOV 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR C. H. Teets and Bros. ADDRESS Brunswick

VS 150

54a

679460

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

679460

BIRTH NO. 59 Registered No.

1. NAME OF DECEASED (Type or Print): Michael M. Kramer

2. DATE OF DEATH: 10/31/49 11:15 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1712 Abbottston st

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1712 Abbottston st 9-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9/8/1864 | 85 | 1 / 23 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Watchman

10B. KIND OF BUSINESS OR INDUSTRY: Pa. R.R.

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Kramer

14. MOTHER'S MAIDEN NAME: Elizabeth Wittic

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Sarah E. Kramer ADDRESS: 1712 Abbottston st.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Regurgitation Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Arteriosclerosis — 1 yr.

DUE TO

(C) Chr. Interstitial Nephritis — 1 yr

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Contusion Scrotum — Unk

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 31, 19 49, to Oct 31, 19 49, *that I last saw the deceased alive on* Oct 30, 19 49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: J Sa Stevens M. D.

23B. ADDRESS: 2878 Hoffman Ln

23C. DATE SIGNED: 11-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/3/49

24C. NAME OF CEMETERY OR CREMATORY: Schartz

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

46E

G79461

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79461

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Milton W. Chiveral

2. DATE OF DEATH: 10/30/49 3 07 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 602 N. Highland Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 602 N. Highland Ave

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 3/31/1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Water Dept City of Balto. | Balto. Md. | |

13. FATHER'S NAME: Wm D. Chiveral

14. MOTHER'S MAIDEN NAME: Sarah J. Pearman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | James L. Chiveral | 5304 Sipple Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Bronchial Asthma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Circulatory collapse

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Ca of Gall Bladder; Cardiac collapse

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1949 *to* Oct 30, 1949 *that I last saw the deceased alive on* 10/30, 1949 *and that death occurred at* 3 07 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. H. Goodman M. D. | 3400 E Balto | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~or CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/2/49 | Balto | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

46F

G79462
MS--16136

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79462

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Durham, Singleton (RICHARD Singleton Durham)

2. DATE OF DEATH 10-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. 38 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07
D. STREET ADDRESS (If rural, give location) ~~Home~~ 2625 Huntingdon Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Feb. 12, 1883 ? | 66 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Maryland | |

13. FATHER'S NAME: Charles H. Durham

14. MOTHER'S MAIDEN NAME: Alcena Gaither

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|---|
| No | | | Records-- Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic heart disease with Coronary occlusion | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 4-15-, 1931 *to* 10-31-, 1949, *that I last saw the deceased alive on* 10-31-, 19 49 *and that death occurred at* 5:00 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| B S Rogers M. D. | Baltimore City Hospitals | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | Bethel | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

937

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G79463

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79463 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry S. Offley

2. DATE OF DEATH 10/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2133 E. Preston St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2133 E. Preston St. 8-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan 6th 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist

10B. KIND OF BUSINESS OR INDUSTRY Lever Machinery Co

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Wm P. Offley

14. MOTHER'S MAIDEN NAME Louisa Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-03-0849

17. INFORMANT Margaret V. Offley ADDRESS 2133 E Preston St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

DUE TO

(B) Mitral Regurgitation Decompensated — 2 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Chronic Rheumatic valvular Nephritis — 9 mo

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension Arteriosclerosis — 4 mo.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1949 to Oct 31, 1949, that I last saw the deceased alive on Oct 31, 1949, and that death occurred at 8:15 P m., from the causes and on the date stated above.

23A. SIGNATURE F. A. Stevens M. D.

23B. ADDRESS 2978 Harford Rd

23C. DATE SIGNED 11-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11/4/49

24C. NAME OF CEMETERY OR CREMATORY Lorraine

24D. LOCATION (City, town, or county) (State) Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St. Paul St

VS 150

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379464

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

10-5

Registered No. 379464

1. NAME OF DECEASED (Type or Print) Margaret Thompson

2. DATE OF DEATH 10-31-49

3. PLACE OF DEATH: A. Baltimore City, Maryland md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE md. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 3375 Beech Ave. 13-06

5. SEX female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 6/26/95

9. AGE (In years last birthday) 54 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing operator

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) md.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME George E. Getz

14. MOTHER'S MAIDEN NAME Appolonia Grubbs.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-07-1844

17. INFORMANT Harry L. Thompson ADDRESS 3375 Beech Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Terminal Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Peptic Ulcer — c

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) Intestinal Obstruction Post operative Gastro-Enterostomy & Cholecysto-Enterostomy.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 10/19/49

19B. MAJOR FINDINGS OF OPERATION Chronic Peptic Ulcer & Intestinal Obstruction

20. AUTOPSY? YES NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in institution, city, give exact location) Hospital.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/25 1949 to 10/31 1949, that I last saw the deceased alive on 10/31, 1949, and that death occurred at 9:01 A m., from the causes and on the date stated above.

23A. SIGNATURE Frank A. Dwyer M. D.

23B. ADDRESS 3 E Lexington St

23C. DATE SIGNED 10/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Nov 3/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Belair Rd. Balto md

DATE RECEIVED BY LOCAL REGISTRAR NOV 2 1949

REGISTRAR'S SIGNATURE Hunterington Williams M.D.

25. FUNERAL DIRECTOR Euston E. Donovan ADDRESS 3818 Poland Ave

VS 150

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C79465

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

C79465

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mollie Michelson

2. DATE OF DEATH: 11-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3105 Virginia Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 55 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3105 Virginia 27-16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Paul Bussman

14. MOTHER'S MAIDEN NAME: Deborah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Aaron Michelson ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic Cardiovascular disease — 25 yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1930 19__ *to* November 1, 1949 *that I last saw the deceased alive on* November 1, 1949 *and that death occurred at* 8-30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Seaman, M. D. | 11 E. Chase St. | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-2-49 | Rosedale | Delto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Instructor Williams, M.D. | Jack Levin Inc | 2100 Eutaw Pl |

VS 150

937

G79466

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

53

G79466

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MAX OBERSITZKO

2. DATE OF DEATH: 11-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4502 Springdale Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28 07

c. Length of stay in Baltimore: 11 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 4502 Springdale Ave

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9

9. AGE (In years last birthday): 72 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leopold

14. MOTHER'S MAIDEN NAME: Therese

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Ludwig Fuller ADDRESS: 4502 Springdale

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of colon disseminated — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible] 48 *to* Nov 1, 19 49, *that I last saw the deceased alive on* Oct 31, 19 49, *and that death occurred at* 5-10 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 2301 Druid Park

23C. DATE SIGNED: Nov 2 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-2-49

24C. NAME OF CEMETERY OR CREMATORY: Rosedale

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

46E

G79467

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79467

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE SHIMP — N-819-7

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: 25 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parkville
D. STREET ADDRESS (If rural, give location): 3000 California Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | widower | November 15, 1862 | 86 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sawmill worker | Sawmill | Pennsylvania | U. S. A. |

13. FATHER'S NAME: Henry Shimp

14. MOTHER'S MAIDEN NAME: Sarah Lausch

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | |

17. INFORMANT — ADDRESS: Balto. 14
Mrs. Aubrey Burton- 3000 California Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fractures, ribs, arm and legs | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public | California Avenue & Harford Rd. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 31, 1949 m. | | Balto. Co. Ped. struck by auto. |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Nov. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | November 3, 1949 | Waugh Chapel | Baltimore County, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams M.D. | Lassahn Funeral Home | 7401 Belair Rd. - Balto. - 6 |

VS 151

per 559

170C

679468

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 679468

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary A. Tarbert
2. DATE OF DEATH: Nov 1st 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 203 Hawthorne Rd.
C. Length of stay in Baltimore — Yrs. — Mon. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 6049 Falls Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Oct. 27, 1874 | 75 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | Home | Balto. Co., Md. | |

13. FATHER'S NAME: Charles Akehurst
14. MOTHER'S MAIDEN NAME: Martha E. Kone

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Elsie V. Foreman | 1167 W. Hamburg St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma - Origin Undetermined — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| William J. Kelbach M.D. | ☐ / ☐ / ☒ | Nov 1st 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Thurlington for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 1

55E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79469

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79469

1. NAME OF DECEASED (Type or Print): ZENAS LINN HOOVER

2. DATE OF DEATH: Oct. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: 23 yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Anneslie, ~~Baltimore~~
D. STREET ADDRESS (If rural, give location): 723 Murdock Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 5/1/90 | 59 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: B&O RR
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John Hoover
14. MOTHER'S MAIDEN NAME: Annie Evans
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Aplastic anemia | over 2 mos. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Thrombocytopenia | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Hemorrhage into viscera | Recent |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 27, 1949 *to* Oct. 31, 1949 *that I last saw the deceased alive on* Oct. 31, 1949, *and that death occurred at* 10:57 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson
John L. Wilson, Medical Director M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 11/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/4/49
24C. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

72a

G79470

MS—132879

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79470 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles H. Harr (Also known as Harry H. Harr)

2. DATE OF DEATH: 11-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1425 Gusryan St. 26-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Jan. 16, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? (D) | ? (D) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 217-26-7205 | Records | Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Lobar pneumonia

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-27-49 | Questionable subdural hematoma | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-24- , 1949 *to* 11-1- , 1949, *that I last saw the deceased alive on* 11-1- , 1949 *and that death occurred at* 6:55 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. L. Rozan M. D. | Baltimore City Hospitals | 11-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/1949 | Oak Lawn Cemetery | Baltimore County, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | Lilly & Zeiler Inc. | 403 S. Wolfe St. Balto. |

VS 150

108

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79471

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

416

G79471 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GLADYS MADELINE BENNETT

2. DATE OF DEATH Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto - Md. 26-08
D. STREET ADDRESS (If rural, give location) 3433 E. Lombard St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | W. | married | Aug. 7 1904 | 45 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Baltimore | U.S.A. |

13. FATHER'S NAME: Samuel Hopkins

14. MOTHER'S MAIDEN NAME: Mary McElderry

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | no | none |

17. INFORMANT: Stanley A. Bennett - 3433 Lombard St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/29, 1949, *to* 11/2, 1949, *that I last saw the deceased alive on* 11/2, 1949, *and that death occurred at* 5:00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Siwinski M. D. | St. Joseph's Hosp. | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial 11/5/49 | 11/5/49 | Balto. Cem. | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR AND ADDRESS: Lilly & Leiler Inc. Balto.

VS 150

93c

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G794472

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0

G794472 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES J GILBRIDE

2. DATE OF DEATH: 11/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 6 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 819 E. Chase St 10 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 8/31/11 | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bartender | Tavern | Pennsylvania | U.S. |

13. FATHER'S NAME: James Gilbride

14. MOTHER'S MAIDEN NAME: Helen Morton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Dorothy Gilbride ADDRESS: 819 E Chase St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of the liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26 19 49 to 11/1 19 49 *that I last saw the deceased alive on* 11/1 19 49 *and that death occurred at* 7 19 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. Krakauer M. D.

23B. ADDRESS: Sinai Hospital

23C. DATE SIGNED: 11/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/5/49

24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem

24D. LOCATION (City, town, or county) (State): Scranton Pa

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Geo. L. Berger Jr. ADDRESS: 1512 Hollins St

VS 150

124 R

G79473

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79473

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Cornelia E. Machin
2. DATE OF DEATH: Oct. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Garrison Nursing Home, 2803 Garrison Blvd.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5511 Narcissus Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | March 9, 1863 | 86 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | ---- | Maryland | |

13. FATHER'S NAME: John J. Brown
14. MOTHER'S MAIDEN NAME: Annie R. Norris

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|---|
| No | ---- | ------ | Mr. Robert E. Machin, 5511 Narcissus Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrh | 10-27-49 |
| DUE TO (B) | Chr. Myocarditis | 1946 |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 16, 1949 *to* Oct. 31, 1949, *that I last saw the deceased alive on* Oct 30, 1949, *and that death occurred at* 12.30 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James Brown, M. D. | 1663 W. North Ave. | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2, 1949 | Druid Ridge Cemetery | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | Ellis Funeral | 4510 Liberty Heights Ave. |

VS 150

937

G79474

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4200

G79474

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William F. Mellis "MELLUS."

2. DATE OF DEATH 30 October - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 516 - Brunswick - St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 516 - Brunswick - St. 20 06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | MAR.-24-1864 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Butcher | Cookeen Hill Co | Germany | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Karl Möbius | Johanna ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 218-10-6060 | Family Records. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis with
DUE TO Cardiac Hypertrophy & Congestive failure.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Type Heart
DUE TO disease - Generalized Arteriosclerosis

(C) Pulmonary Oedema.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 24, 1949 *to* Oct 30, 1949 *that I last saw the deceased alive on* Oct 30, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 1015 Fayette & Bond St | Oct 31 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2/49 | Western Cemetery | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | J. B. Peppard & Son | 1300 Eutaw Pl. 17 |

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79475

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79475

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward M. Pruitt

2. DATE OF DEATH: 30 October 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 533 Rossiter Ave.
c. Length of stay in Baltimore: Yrs. 27 Mon. 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 533 Rossiter Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | April 12 1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Snow Hill Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Pruitt
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Edward M. Pruitt — ADDRESS: (Same)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic C-V disease | 5 years |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Bronchiectasis | 5 years |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1942 *to* Oct. 30, 1949 *that I last saw the deceased alive on* Oct. 29 1949, *and that death occurred at* 2 00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. H. Spencer M.D.
23B. ADDRESS: 1402 E. Fayette St
23C. DATE SIGNED: 10-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 2/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial
24D. LOCATION (City, town, or county) (State): Jersey Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: F. B. Gilbert & Son
ADDRESS: 130 Eutaw St.

VS 150

92D

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

Q79476

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. Q79476

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NORMAN ROGER MELLOR — 237

2. DATE OF DEATH October 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Catonsville
D. STREET ADDRESS (If rural, give location) 3235 Stonewall Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | 9/18/1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| electrician | Electric | Maryland | |

13. FATHER'S NAME: Albert Mellor

14. MOTHER'S MAIDEN NAME: Laura Hogan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | | Mrs. Madeline Mellor | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Brain tumor--meningioma with recurrence | approx. 5 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| approx. 5 yrs. ago | Brain tumor -- meningioma | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| R K Graber M.D. M.D. | | Nov. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | GOOD SHEPPARD ~~St. Johns~~ | Ellicott City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Funeral Director Baltimore, Md. | MacNabb & Son | |

VS 151

569

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79477 ✓ X G79477

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

578 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LEAH CLAUSS

2. DATE OF DEATH 10/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glen Burnie
D. STREET ADDRESS (If rural, give location) Route #2 (Ogle's Road)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | July 13 '11 | 38 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | Own Home | Md | |

13. FATHER'S NAME Samuel T. Royer

14. MOTHER'S MAIDEN NAME Grace B. Royer ✓

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | None | William D. Clauss | Glen Burnie |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(B) Perforated ulcer of sigmoid
DUE TO
(C) Non-specific ulcers recto-sigmoid

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/20 19 49 to 10/31 19 49, *that I last saw the deceased alive on* 10/30 19 49, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Blanck M.D. | Maryland General | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 2, 1949 | Cedar Hill | Brooklyn P.O. A.A.Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949

REGISTRAR'S SIGNATURE: [illegible]

25 FUNERAL DIRECTOR (ADDRESS) Thomas W. Singleton

VS 150

120B

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79478

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

150

G79478

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): O'Hara. Patrick

2. DATE OF DEATH: 11-1-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY: Baltimore.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1506 W. Fayette St. 19-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male. | White | married | 12-6-1880 | 68 | 11 | 5 | 18 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none. | | Virginia | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick O'Hara. | Catherine Fitzgerald. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Bernice O'Hara | 1506 W. Fayette St. Balt. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Empyema, left Chest

DUE TO

(B) Perforation of Esophagus post operative to resection of Esophagus for

DUE TO

(C) Carcinoma of the esophagus & metastasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/19/49 | Carcinoma of the Esophagus & Metastasis | YES [1] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-2-, 1949, *to* 11-1-, 1949, *that I last saw the deceased alive on* 11-1-, 1949, *and that death occurred at* 6:03 pm, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Ramundo M. D. | 1 Wilson Med | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11/5/49 | | Richmond | Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | Fred. H. Ober | 1913 W. Baltimore St. |

VS 150

46a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79479

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79479

BIRTH NO. 49-23272

1. NAME OF DECEASED (Type or Print): Baby Girl Maloney

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mon. Days: 1 da.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5423 Pembroke Ave. 27-34

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Single | Oct. 30, 1949 | | | 2 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore | |

13. FATHER'S NAME: John Martin Maloney

14. MOTHER'S MAIDEN NAME: Mary Louise Ries

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 30, 1949 *to* Nov. 1, 1949, *that I last saw the deceased alive on* Nov. 1, 1949, *and that death occurred at* 6:15 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank W. Baker, Jr. M. D. | 1400 N. Caroline St. | Nov. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 2, 1949 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Registrar of Vitals, M.D. | Leonard J. Rusch | 5305 Harford |

VS 150

159

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79480 MB—132449

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

581.0

G79480 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Cushing or George A Cushing

2. DATE OF DEATH: 10-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 426 S. Eaton St. Z-24 76-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Jan. 13, 1913 | 36 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber | Hamil Co | Maryland | |

13. FATHER'S NAME: Joseph Cushing

14. MOTHER'S MAIDEN NAME: Cunnie Knapp (D)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes World War II | | Records—Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemhorrage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Esophageal varices

DUE TO

(C) Cirrhosis of the Liver

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-25-49 | Porto-canal shunt for esophageal varices due to cirrhosis of Liver | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-8-4, 1949 *to* 10-31-, 1949, *that I last saw the deceased alive on* 10-31-, 1949, *and that death occurred at* 9:30P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Rogers M. D. | Baltimore City Hospitals | 11-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 3 1949 | Baltimore National | Frederick Road MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 2 1949 | [illegible] | Duffy Bros. 1800 E Lombard St. |

VS 150

1248

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G79481 ✓ G79481

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MARY-ELEANORA-CLINTON VOYCE

2. DATE OF DEATH Oct 31 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashburton House 3520 N. Hilton Road

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1405 S. Charles Oakland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1405 S Charles St 23-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W. | Widow | 10/8/860 | 89 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Baltimore Md | |

13. FATHER'S NAME John Clinton

14. MOTHER'S MAIDEN NAME Mary Kelly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| — | — | St Mary Victoria |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

DUE TO Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Cardiac decompensation

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* January 7, 19 44, *to* Oct 31, 19 49, *that I last saw the deceased alive on* Oct 20, 19 49, *and that death occurred at* 2.35 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. Edwin Muller M. D. | 2 W Read St | Oct 31 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 2 1949 | Cathedral | Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | WORLD WAR II DECEASED | J. J. Fahey & Sons | 12 S Eutaw St |

937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79482

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. G79482

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELVINA BAYNARD

2. DATE OF DEATH 11/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore 8 Yrs. 0 Mos. 22 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore # 12
D. STREET ADDRESS (If rural, give location) 4602 York Rd, 27-11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | (Widowed) | Dec 15 '68 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hsw.

10B. KIND OF BUSINESS OR INDUSTRY Housework

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard P. Brown

14. MOTHER'S MAIDEN NAME Rebecca Sleypmann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Radetha M. Heinz ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertension, Arteriosclerotic Cardiovascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/1, 19 49 *to* 11/2, 19 49 *that I last saw the deceased alive on* 11/1, 19 49 *and that death occurred at* 3:20 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Bloch, M. D.

23B. ADDRESS Maryland General

23C. DATE SIGNED 11/2/49

24A. (BURIAL, CREMATION, REMOVAL (Specify)) Burial

24B. DATE Nov. 5/49

24C. NAME OF CEMETERY OR CREMATORY Greenmount

24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR NOV 2 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Philip Herring Sons ADDRESS 2024 Orleans St.

VS 150

931

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79483

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G79483

BIRTH NO. 49-18594 753 / Registered No.

1. NAME OF DECEASED (Type or Print): Richard Michael Smith
2. DATE OF DEATH: 11/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 1020 E. Hoffman St. 9 29

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | Aug 18th 1944 | | 2 15 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: George Smith
14. MOTHER'S MAIDEN NAME: Helen Smith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mr Smith 1020 E Hoffman St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cortical agenesis, congenital
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/15/49, 19__, *to* 10/24/49 19__, *that I last saw the deceased alive on* 10/24/49, *and that death occurred at* ? A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. N. Kastor M. D. | c/o Sinai Hosp. | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 3rd 1949 | Leatheridal | Edmondson Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 2 1949 | Registrar for Baltimore, Md. | Leo G. Leach 1703 N. Patterson Park Ave |

VS 150

157 D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79484 G79484

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 31 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Francis J. Lowe

2. DATE OF DEATH: Nov. 1 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 212 E. Barney St.
C. Length of stay in Baltimore: Yrs. Life. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 212 E. Barney 24-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 3-15-1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Balto. Md. | |

13. FATHER'S NAME: William Lowe

14. MOTHER'S MAIDEN NAME: Elizabeth F. McCall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT / ADDRESS: Thomas J. Lowe 212 E. Barney St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

DUE TO

(B) — Partial Paralysis — 5 days.

DUE TO

(C) — Arterial Hypertension — 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 28, 1949, *to* Nov 1, 1949 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 5.20 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1279 Fulham St | 11-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | Holy Cross | G. G. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 2 1949 | Huntington Williams M.D. | Flynn - Fleming 1426 Light St. |

832a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79485

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79485

1. NAME OF DECEASED (Type or Print): John S. SEITZ

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1809 Ensor St. 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Widowed | May 9, 1876 | 73 | 5 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Night Watch an | Balto. Saleshook | Pennsylvania | |

13. FATHER'S NAME: Andr w Seitz

14. MOTHER'S MAIDEN NAME: Elizabeth Schaeffer (emw)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | 219-01-1263 | Mrs. Leah McCann, 39 Balto. St. Glen Rock, Pa. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: B K Fisher M D

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 1, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 4th 1949 | Reformed Cemetery | Glen Rock Pa. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949

REGISTRAR: Huntington Williams, M.D. Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Grant Della Noce 322 S. High St.

VS 151

93D

G79486 ✓X G79486

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

BIRTH NO. 146 Registered No.

1. NAME OF DECEASED (Type or Print): JAMES WALTER GEORGE

2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Foxwell
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 1/17/82 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Captain | Seafarer | Virginia | USA |

13. FATHER'S NAME: Thomas George

14. MOTHER'S MAIDEN NAME: Mary Lizzie Showers

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ? | | ? | Records- | US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Nephrosclerosis with vascular hypertension — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

(B) Congestive heart failure and uremia ( terminal)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 26, 1949 *to* Nov. 2, 1949, *that I last saw the deceased alive on* Nov. 2 1949 *and that death occurred at* 12 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Whitestone Cemy. | Lancaster Co. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | John D. Hirtzell Sons | 1900 Eutaw Place |

131a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79487 G79487

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 59
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bertha R. Kenly
2. DATE OF DEATH: 10-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3928 Frisby St
C. Length of stay in Baltimore: Yrs. 9 Mos. 0 Days 1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3928 Frisby St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 11/27/80
9. AGE (In years last birthday): 68 69
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Ruhmann
14. MOTHER'S MAIDEN NAME: Mary Niles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Catherine Warfield
ADDRESS: 733 Overbrook Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO Chronic Nephritis
INTERVAL BETWEEN ONSET AND DEATH: 3 Days. 10 yrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 1947 *to* Oct. 31, 1949, *that I last saw the deceased alive on* Oct. 30 1949, *and that death occurred at* 6:00 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lloyd E. Taylor M. D.
23B. ADDRESS: 3902 Greenmount Ave.
23C. DATE SIGNED: Nov. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-3-49
24C. NAME OF CEMETERY OR CREMATORY: Govans Presbyterian
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3000 E. Balt. St.

1318

G79488

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79488

Registered No.

BIRTH NO. 49-12549

1. NAME OF DECEASED (Type or Print): Robert Wharton

2. DATE OF DEATH: November 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 246 N Fulton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | single | June 11 1949 | | 5 | 21 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | — | City Hosp, Balto | USA |

13. FATHER'S NAME: Robert A. Wharton

14. MOTHER'S MAIDEN NAME: Jeanette Keilholtz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: —

17. INFORMANT: Mrs Mable A Keilholtz ADDRESS: 246 N Fulton Ave

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) lung abscess ? | ? |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-1-49 19__, *to* 11-2-49, 19__, *that I last saw the deceased alive on* 11-1 1949, *and that death occurred at* 7 00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Diephs M. D. | Mercy Hosp | 11-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | Holy Cross Cem. | Ritchie Hgwy Brooklyn |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams, M.D. | John J. Cowan & Son | 701 Fulton Ave. |

1149

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79489

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

51 Registered No. G79489

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kezia Sydnor

2. DATE OF DEATH: Oct 30 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1927 Madison Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-0

c. Length of stay in Baltimore: 40 years. Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1927 Madison Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colred | Widow | Nov. 28, 1877 | 71 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Lancaster Co. Va | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Solomon Cooper | Hannah Yerby |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | William Lyles Cooper | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH 1016 Stricken

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignancy of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B) None

DUE TO

(C) none

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 14 Oct, 1949, to 30 Oct, 1949, *that I last saw the deceased alive on* 30 Oct, 1949 *and that death occurred at* 9:0 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James D. Carr, M. D. | 1427 Madison Ave | 11-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Nov. 3, 1949 | Arbutus Mem. Pk. | Baltimore Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Kenneth Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

MS 150

46B

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79490

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

154 Registered No. G79490

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sister Lydia Hearne

2. DATE OF DEATH: 11/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital of the City Baltimore
c. Length of stay in Baltimore: 2 Months - 2 days (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Penna
B. COUNTY: St Vincents Home Lansdowne
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lansdowne
D. STREET ADDRESS (If rural, give location): Drexel Hill

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | | 5/3/1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Religious | School | Ireland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Hearne | Mary Joyce deceased |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT / ADDRESS |
|---|---|---|
| NO | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Renal Failure
DUE TO
(B) Metastases from
DUE TO
(C) Retinalum Cell Sarcoma Rectum.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 9/20/49 | Retinalum Cell Sarcoma - Rectum | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/31, 1949 *to* 11/1, 1949 *that I last saw the deceased alive on* 11/1, 1949 *and that death occurred at* 1 45 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank O Dwyer Jr M. D. | St Agnes Hosp | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/3/49 | Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 2 1949 | for Baltimore, Md. | M. Faher & Sons 1827 W. North Ave. |

VS 150

467

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

BIRTH NO. G79491

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4201 G79491 Registered No.

1. NAME OF DECEASED (Type or Print): JOHN PATRICK COTTER

2. DATE OF DEATH: October 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 710 S. Clinton Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 24, 1897 | 52 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | AA Fertilizer Co. | Baltimore | U.S.A. |

13. FATHER'S NAME: Patrick Cotter

14. MOTHER'S MAIDEN NAME: Mary Behr

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | World War I | 213-10-5122 | Ida Cotter | 710 S. Clinton St. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-3-49 | Sacred Heart Cemetery | German Hill Rd. Balto. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 1949 | Huntington Williams M.D. | Charles L. Zeiler | 901 S. Conkling St. |

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79492 ✓ X 61 G79492

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES B McQUAY
2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL
C. Length of stay in Baltimore: ~~Yrs.~~ ~~Mos.~~ 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: CARROLL
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WESTMINSTER
D. STREET ADDRESS (If rural, give location): R.F.D #4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | 10/30/84 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PLANT OPERATOR
10B. KIND OF BUSINESS OR INDUSTRY: WATER WORKS
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WILLIAM H. McQUAY
14. MOTHER'S MAIDEN NAME: JULIE KAUFMAN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Patient ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | UREMIA | 4 WKS. |
| DUE TO (B) | PROSTATIC HYPERTROPHY | 6 MONTHS |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/31, 1949, *to* 11/2, 1949 *that I last saw the deceased alive on* 11/2, 1949, *and that death occurred at* 2:20 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul G. Hurd M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 11/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: NOV. 5. 1949
24C. NAME OF CEMETERY OR CREMATORY: Westminster Cem.
24D. LOCATION (City, town, or county) (State): Westminster Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 2 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: J. F. Myers Jr. ADDRESS: 137a Westminster Md.

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79493

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79493 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES J. TRAGESER

2. DATE OF DEATH: Nov 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTIMORE GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 12-04
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2114 N Calvert St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Nov 26, 1864 | 84 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager Tailor
10B. KIND OF BUSINESS OR INDUSTRY: C & P Telephone Co
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Christian Tragesser
14. MOTHER'S MAIDEN NAME: Margaret Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Wm Anna E Tragesser ADDRESS: 2114 N Calvert St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cereb - vascular hemorrhage
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive arteriosclerotic CVD
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 5 days
(B) !
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Shea M. D.
23B. ADDRESS: West Baltimore Gen Hosp
23C. DATE SIGNED: 11/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/6/49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson & Son ADDRESS: 2114 N Calvert St

VS 150

93D

G79494

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

150 Registered No. G79494

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gonano, August

2. DATE OF DEATH: 2 Nov. 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY: 26-07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. of Balto., Inc.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto

c. Length of stay in Baltimore: Yrs. Mos. Days

d. STREET ADDRESS (If rural, give location): 404 S Lehigh St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widow | Feb 11 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stone Mason | Stone work. | Italy | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 213-18-9710 | Edith Barnard Silver Spring Md | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Carcinoma of Oesophagus — Interval between onset and death: Known 10 months

DUE TO

(b) Mediastinitis, Auricular Sibrillation

DUE TO

(c)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 25 Oct 49 | Carcinoma of middle 1/3 of oesophagus | YES ✓ NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/10, 1949 to 11-2, 1949, *that I last saw the deceased alive on* 11-2, 1949, *and that death occurred at* 2:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Eugene P Sheehan M. D. | Sinai Hospital | 2 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11/5/49. | Oak Lawn | Govdale Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | William Cohen | 1217 S Paca St |

VS 150

46a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If unknown, state so. Be sure to give correct age in years, months, days or hours. Physician: please write the cause of death clearly and legibly. Cause of death is especially important.

G79495

BIRTH NO. G79495

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79495

1. NAME OF DECEASED (Type or Print): VALENTINE A. HULTIN

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1009 Cathedral St.

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 11-02
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1009 Cathedral St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 3, 1885 | 64 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | Glen L. Martin | Sweden | |

13. FATHER'S NAME: Adolph Hultin

14. MOTHER'S MAIDEN NAME: Helena Fredericks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 216-12-0119

17. INFORMANT: Mrs Margie Hultin, ADDRESS: 1009 Cathedral St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Cardiac Dilatation | 5 da |
| DUE TO | | |
| (B) | Chronic Myocarditis | |
| DUE TO | | |
| (C) | Arteriosclerosis | 2 yrs. |

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 26, 1949 *to* Nov. 1, 1949, *that I last saw the deceased alive on* Nov. 1, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert C. Blake | 401 Med arts Bldg | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | Moreland Park | Baltimore County, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

931

G79496

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153 Registered No. 157997

G79496

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SOPHIA K. ROSE

2. DATE OF DEATH: 11-1-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-04
D. STREET ADDRESS (If rural, give location): 705 Walnut Ave #29

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 2-22-1872
9. AGE (In years last birthday): 77 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick W. Spindler
14. MOTHER'S MAIDEN NAME: Louise Windus
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Bernard Rose ADDRESS: 705 Walnut Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of transverse colon with metastasis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Generalized arteriosclerosis — ?

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/29 1949 *to* 11/1 1949 *that I last saw the deceased alive on* 11/1 1949 *and that death occurred at* 10:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert A Kerr M. D.
23B. ADDRESS: St Agnes Hospital
23C. DATE SIGNED: 11/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 4. 1949
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Wms. John H. Triplett Son ADDRESS: 5311 Edmondson Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 150

46E

G79497

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

5/16

G79497

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MERRILL L. SNYDER

2. DATE OF DEATH 11-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSP.
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY 29 Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 4337 D. ALAN DRIVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | SING. | 1945 - FEB 13 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| child | — | WASHINGTON, D.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| MERRILL J. SNYDER | MURIEL G. GOODWIN |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | | MERRILL J. SNYDER | 4337 D. ALAN DRIVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Laryngotracheobronchitis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. asphyxia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/2, 1949, *to* 11/2, 1949, *that I last saw the deceased alive on* 11/2, 1949, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edwin M. Hubbard M.D. | Univ. Hosp. | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-3-49 | Arlington | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams M.D. | Jack Lewis Inc. | 2100 Eutaw Pl. |

VS 150

106 c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79498

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79498

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN SOSNER

2. DATE OF DEATH: 11-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11

D. STREET ADDRESS (If rural, give location): 3321 Telle Ave

c. Length of stay in Baltimore: Life Yrs. Mos. Days

8. DATE OF BIRTH:

9. AGE (In years last birthday): 42

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Revie

14. MOTHER'S MAIDEN NAME: Leah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Betty Sosner ADDRESS: 3321 Telle Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Coronary thrombosis

DUE TO

arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 Wk

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 15 19 49 *to* 11-2 19 49 *that I last saw the deceased alive on* 10/28 19 49 *and that death occurred at* 9:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 2320 Eutaw

23C. DATE SIGNED: 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-3-49

24C. NAME OF CEMETERY OR CREMATORY: Herring Run

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jos. Sensbrenner Sons ADDRESS: 2100 Eutaw Pl

VS 150

94a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician, please write the causes of death clearly and legibly.

679-99

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 679-99

BIRTH NO

1. NAME OF DECEASED (Type or Print): Mary E. Pohlman

2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1430 E. Lanvale St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1430 E. Lanvale Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | married | Oct. 21, 1871 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | home | Baltimore, Md. | USA |

13. FATHER'S NAME: Edward Stansbury

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Charles W. Pohlman | 1430 E. Lanvale Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma, Face, with Complete Erosion Rt. Orbit — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, J. M.D. | | Nov. 2, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/4/49 | Loudon Park Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

VS 151

53

G79500

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 1

G79500

BIRTH NO.

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Philip K Clarke

2. DATE OF DEATH: November 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Haven Nursing Home 4515 Garrison Blvd
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 1810 Wilhelm St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 25, 1897 | 52 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Asaph Clarke
14. MOTHER'S MAIDEN NAME: Sophie Grabe
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Sister ADDRESS: Fannie Schaffer - 1810 Wilhelm St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (94A) (A) Coronary Occlusion | 1 hrs |
| DUE TO | Complete heart block | 1 hrs |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Chronic Myocarditis & | 5 years |
| DUE TO | Myocardial Degeneration | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1947, *to* November 2, 1949, *that I last saw the deceased alive on* November 1, 1949, *and that death occurred at* 4.50A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Borden M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 11/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 5 '49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): 2930 Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Waltke
ADDRESS: 4101 Edmondson Ave

VS 150

937

9501 BALTIMORE CITY HEALTH DEPARTMENT G79501

# CERTIFICATE OF DEATH

BIRTH NO. 49-22955 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Seitz (NANCY LOU)
2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ARBUTUS
D. STREET ADDRESS (If rural, give location): 1229 TEN OAKS AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | Oct. 14, 1949 | | | 19 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: FREDERICK SEITZ
14. MOTHER'S MAIDEN NAME: MARY HART

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT FATHER ADDRESS |
|---|---|---|
| | | FREDERICK SEITZ - 1229 TEN OAKS RD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchopneumonia | 2 days |
| DUE TO (B) | Cleft Palate & Hare Lip | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Supernumerary digits | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ✓ NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 14, 1949 *to* Nov. 2, 1949 *that I last saw the deceased alive on* Nov. 2, 1949, *and that death occurred at* 9:10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Daniel L. Silverstein M.D. | West Balto. General Hosp. | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | ADDRESS |
|---|---|---|---|---|
| BURIAL | NOV. 3'49 | LOUDON PK | BALTIMORE MD | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| NOV 3 1949 | for Williams, M.D. | Harry A. Wiltze - 410 Edmondson Ave |

VS 150

107

C79502
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

$1.0

C79502
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) ANN B. MOORE

2. DATE OF DEATH October 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St.Jos. Hospital
C. Length of stay in Baltimore 25 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY 12-07
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 3042 Remington Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Divorced | May 7, 1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME James C. Commerse
14. MOTHER'S MAIDEN NAME Ann Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ---

17. INFORMANT ADDRESS Mrs. Lucille C. Hunt 2804 Whitney Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of Liver
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH:
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED Oct. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Nov. 3, 1949
24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park
24D. LOCATION (City, town, or county) (State) Howard Co., Maryland

DATE RECEIVED BY LOCAL REGISTRAR NOV 3 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Burgee Funeral Home 3631 Falls Road

VS 151

1240

G79503

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

253

G79503

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SARAH Jane MARTIN

2. DATE OF DEATH 11/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U of Md. Hosp

c. Length of stay in Baltimore Yrs. Mos. Days 1 1

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parkton Rural
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Oct 11-1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | - | Maryland | USA |

13. FATHER'S NAME Emory Hare

14. MOTHER'S MAIDEN NAME Elyabeth Lee

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | - | Mrs Betty Ruby | same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myxedema — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Uremia. — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 4/1/49, 19 , *to* 4/21, 1949, *that I last saw the deceased alive on* 11/2, 1949, *and that death occurred at* 11:00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E Hall Jr M. D. | U of Md Hosp | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 5-1949 | Grace Meth. | Balto Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | Edw A Tipton | Hampstead Md |

VS 150

63c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79504

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. G79504

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should correct age is especially important. Physicians: please write the cause of death clearly and legibly. Carefully supplied

1. NAME OF DECEASED (Type or Print): Catherine V. Jennings

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2845 Pelham Ave.
C. Length of stay in Baltimore: 63 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-01
D. STREET ADDRESS (If rural, give location): 2845 Pelham Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hrs. / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | June 14, 1869 | 80 | 4 | 18 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Work | at Home | Ireland | U.S.A. |

13. FATHER'S NAME: William Dorsey

14. MOTHER'S MAIDEN NAME: Catherine Whelan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | No |

17. INFORMANT: Mrs. William P. Jennings ADDRESS: 2845 Pelham Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy.

DUE TO

(B) Arterio Sclerosis, Emphysema & Myocarditis.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Sept 10, 19 49 *to* Nov 1, 19 49, *that I last saw the deceased alive on* Oct 31, 19 49, *and that death occurred at* 10 05 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Scheurich M. D. | 1337 S. Charles St. | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 5, 1949 | New Cathedral Cemetery | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | Elmer W. Conklin | 924 E. Eager St |

VS 150

931

G79505

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 ✓

Registered No. G79505

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAMIE BOYD

2. DATE OF DEATH: 10/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1407 MOSHER. ST.

C. Length of stay in Baltimore: 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 16-12
D. STREET ADDRESS (If rural, give location): 1407 Mosher St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | colored | Widowed | 1864 (1884) | 65 | Jan | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Tobias Henson

14. MOTHER'S MAIDEN NAME: Charlotte Goodrich

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Leola Reddic ADDRESS: 1407 Mosher st

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3-5 days

DUE TO

(B) Chr. Glomerular nephritis — 2

DUE TO

(C) Hypertensive Cardiovascular Renal disease. — 2

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1948, to Oct 30, 1949 *that I last saw the deceased alive on* Oct 29, 1949, *and that death occurred at* 12½ p m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Leland Shirell Jr M. D.

23B. ADDRESS: 902 W. Franklin

23C. DATE SIGNED: 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-3-49

24C. NAME OF CEMETERY OR CREMATORY: Asbury Annapolis

24D. LOCATION (City, town, or county) (State): Annapolis Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: William A. Cadson ADDRESS: 916 Penna ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to give correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 150

131a

✓ Medical Examiner's Case (Notified 11-2-49)

G79506 BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH E900

BIRTH NO. Registered No. G79506

1. NAME OF DECEASED (Type or Print) Alice Mitchell Reed. N-8110

2. DATE OF DEATH 2 Nov 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

c. Length of stay in Baltimore 6 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 27-14

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10

D. STREET ADDRESS (If rural, give location) 114 Woodlawn Road.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | WIDOWED | 9 Sept 1862 | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | None. | Delaware | U. S. A. |

13. FATHER'S NAME James W. Mitchell

14. MOTHER'S MAIDEN NAME Elizabeth P. Lank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, prior unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17 INFORMANT Daughter. ADDRESS Same.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3days.

DUE TO

(B) Fractured left hip — 10days

DUE TO

(C) Generalized arteriosclerosis — Yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY Dr. John R. Davis per [signature] CORONER OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 28 October 1949 | Fracture of neck of [illegible] | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home. | 114 Woodlawn Rd. 10 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 23 October 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Pt fell down 3 stairs 27/14 |

22. *I hereby certify that I attended the deceased from* 24 October 1949 *to* 2 November 1949 *that I last saw the deceased alive on* 2 November 1949, *and that death occurred at* 3 20 p. m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wayne N. Jacobus M.D. M. D. | Church Home & Hospital | 11-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/3/49 | St. Peters Cem | Smyrna, Del. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians—please write the cause of death clearly and legibly.

186a

G79507

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

45 1

G79507 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Frank Stanley Barnes

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2218 Annapolis Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | June 2, 1892 | 57 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Helper | retail Building supplies | Sykesville, Md. | |

13. FATHER'S NAME: Ferdinand A. Barnes

14. MOTHER'S MAIDEN NAME: Catherine Lennon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Evelyn V. Barnes ADDRESS: 2218 Annapolis Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Tamponade

DUE TO

(B) Rupture of aorta

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Dissecting aneurysm
Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McCafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Nov. 1, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | Moreland Mem. Pk. | Howard Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: Balto., Md.

VS 151

30

G79508

49-22062

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1605

Registered No. G79508

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 26 hrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County —
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
16-02 (d) Street No. 1120 N. Stricker St #17 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Baby Girl Cook.

| 3 (b) If veteran, name war | 3 (c) Social Security Account No. |
|---|---|
| — | None |

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| Female | Colored | Single |

6 (b) Name of husband or wife none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1949

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | — | 38 hr. — min. |

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none.

FATHER
12. Name Roy Cook
13. Birthplace New Blackstone, Va.

MOTHER
14. Maiden Name Scroggins
15. Birthplace New Blackstone, Va

16 (a) Informant Father.
(b) Address 1120 N. Stricker St Apt.

17 (a) City Disposal (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 26 1949

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 3 1949 (Date rec'd by registrar) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Oct 15, 1949, at 7:00 PM

**21.** I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1949, to Oct 15 1949, and that I last saw her alive on Oct 15 1949.

| Immediate cause of death | Duration |
|---|---|
| Asphyxia. | |
| Due to Congenital atelectasis & central hemorrhage | |
| Due to Prematurity. | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

**22.** If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

**23. Signature** R. J. Graham, M.D. M. D.
Address University Hosp. Date signed 10/16/49.

160a

VS 150

G79509

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54:4 G79509 Registered No.

BIRTH NO. 49-01105

1. NAME OF DECEASED (Type or Print) DONNA MARIE ~~GRECCO~~ GRECCO

2. DATE OF DEATH Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-03
D. STREET ADDRESS (If rural, give location) 101 N. Patterson Park Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Jan 22 1949 | | 10 9 10 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore | |

13. FATHER'S NAME: Dominic M. Greece

14. MOTHER'S MAIDEN NAME: Georgette Melzer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Dominic M. Greece | 101 N. Patterson Park Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Mongolian idiocy

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED 11/2/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 4 1949 | Holy Redeemer Cemetery | 4430 Belair Rd. Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Remington Williams, M.D. | Frank Della Rose | 322 S. High St. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

157E

G79510 ✓ G79510

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 190

BIRTH NO. 49-19541

1. NAME OF DECEASED (Type or Print): Vernon Jones

2. DATE OF DEATH: 11-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1115 Brewer St ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | Negro | Single | Aug. 29, 1949 | | 2 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | none | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert Jones | Catherine Campbell ✓ |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Catherine Campbell | 1115 Brewer St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Right Bundar Pneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-1 *19*49 *to* 11-2 *, 19*49 *that I last saw the deceased alive on* 11-2 *, 19*49 *and that death occurred at* 10:25 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. H. Beady Jr. M. D. | Provident Hosp | 11-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | Mt. Calvary Cemet. | Cedar Hill, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | A. Halstead | 918 Druid Hill Ave. |

vsl-58

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

108

G79511 ✓ G79511

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4 - 1 Registered No.

1. NAME OF DECEASED (Type or Print): PHILIP W. ROEDER. 2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 509 S. CHAPEL ST.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 2-03

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 509 S. CHAPEL ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | 3/19/1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PRESS HAND | CAN SHOP | MARYLAND | U.S.A. |

13. FATHER'S NAME: MORTON ROEDER.

14. MOTHER'S MAIDEN NAME: WILHELMINA SCHULTZ.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 215-01-0140 | MRS. H. SEIFERT | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: acute

DUE TO

(B) Cerebral Arterio-sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 7, 19 49 *to* Nov 7, 19 49 *that I last saw the deceased alive on* Nov 7, 19 49 *and that death occurred at* 6:15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1001 E Pratt St | 11/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11/7/1949 | MT. CARMEL | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | [signature] for Williams, MD | WILLY & ZEILER INC. | BALTO, MD. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

BIRTH NO. G79512

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G79512

1. NAME OF DECEASED (Type or Print): Beaufort C. Holland

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 16-03
D. STREET ADDRESS (If rural, give location): 1017 N. Fulton Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-24-1884
9. AGE (In years last birthday): 65 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office
10B. KIND OF BUSINESS OR INDUSTRY: H. Johnson Ins.
11. BIRTHPLACE (State or foreign country): Moutain Veiw, N.C.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Calvin Holland
14. MOTHER'S MAIDEN NAME: Rebbecca Southern
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Mable Holland, ADDRESS: 1017 N. Fulton Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Nov. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 11/12/49
24C. NAME OF CEMETERY OR CREMATORY: SLATE FUNERAL HOME
24D. LOCATION (City, town, or county) (State): KING NORTH CAROLINA

DATE RECEIVED BY LOCAL REGISTRAR: NOV 3 1949
REGISTRAR'S SIGNATURE: Curtis Williams, M.D.
25. FUNERAL DIRECTOR: J. F. STANSBURY ADDRESS: 2106 EDMONDSON AVE

VS 151

937

G79513

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 20.1 G79513

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDITH C. O'DELL

2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-06; D. STREET ADDRESS (If rural, give location) 2733 Rayner Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Md Hosp

C. Length of stay in Baltimore: Yrs. 40 Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | single | 4/29/1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Reg. Nurse | RETIRED | Canada | USA |

13. FATHER'S NAME: MELANCTHON O'DELL

14. MOTHER'S MAIDEN NAME: MARY J. DINNER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | CARL [illegible] O'dell | CATONSVILLE STATION MD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension, arteriosclerotic cardio vascular disease — 2 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/1/49, 19 , *to* 11/2, 1949 *that I last saw the deceased alive on* 11/2, 1949, *and that death occurred at* 1120A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E Holt, Jr. M. D. | U. of Md Hosp | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11/12/49 | WESTERN | BALTIMORE | MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | J. J. STANBURY | 2200 EDMONDSON |

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please answer all questions. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79514

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

141 G79514

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nicholas Meile

2. DATE OF DEATH: 11/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

c. Length of stay in Baltimore: 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06
D. STREET ADDRESS (If rural, give location): 927 n Rosedale St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | August 2, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | Globe Brewing | Washington D.C. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Meile | Augusta ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | WW 1 | 214.01.9432 | Mary C. Meile | 927 Rosedale St. |

## MEDICAL CERTIFICATION

CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Tbc. | ? |
| DUE TO (B) | Carcinoma of the Tongue (over) | ? |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/ , 1949, *to* 11/ , 1949, *that I last saw the deceased alive on* 11/ , 1949, *and that death occurred at* 11 10 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles T. Lauderman M.D. | Univ. Hospital | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | Balto. National | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams M.D. | J.T. Stansbury | 2700 Edmondson Ave. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Symptoms, duration, contributory causes, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45 C

G79515

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

63 G79515

Registered No.

1. NAME OF DECEASED (Type or Print): Thomas William McKane

2. DATE OF DEATH: November 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 621 North Calvert Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 1258 S. Ringgold Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Widowed | May 1, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman & Engineer | B. F. Goodrich Co. | Ireland | |

13. FATHER'S NAME: Thomas McKane

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | |

17. INFORMANT: Mrs. Georgieanna Sine, ADDRESS: 621 N. Calvert St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma Lung | 1 yr |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 9-32, 19 49, *to* 11-3, 19 49, *that I last saw the deceased alive on* 11-2, 19 49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|---|
| John P. Ulrich, Jr. | | 1227 Wash. Blvd | 11-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/3/49 | Mt. Moriah Cemetery | Philadelphia, Pennsylvania |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

VS 150

47D

PLEASE WRITE PLAINLY. Please write the causes of death clearly and legibly. Physician, please write the correct age is especially important.

G79516 G79516

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No. 334

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HELEN ETCHISON BIGLEY
2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4509 Roland Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-14
D. STREET ADDRESS (If rural, give location): 4509 Roland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|
| female | white | widowed | Sept. 28, 1873 | 76 yrs. |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | own home | West Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| L. E. Ephriam Etchison | Elizabeth Lansdale |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. E. Bigley Sharretts | 4509 Roland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Apoplexy | |
| DUE TO (B) | Arteriosclerosis, cerebral | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 2:a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Laurence R Wharton M. D. | 1201 N. Calvert St. | 11-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/5/49 | Glenwood Cem. | Wash., D.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

PLEASE WRITE PLAINLY. Please fill in all blanks. Be sure the cause of death is correct as is especially important. Physicians: please write the cause of death clearly and legibly.

83a

G79517

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153 G79517

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Marie Angelme Laughlin

2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16-07
D. STREET ADDRESS (If rural, give location): 1010 Popular Grove

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | July 1, 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Printing Co | Md. | U.S.A. |

13. FATHER'S NAME: Patrick McLaughlin

14. MOTHER'S MAIDEN NAME: Emily Miles

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 213-05-9694 | Deceased | as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Hepatic Flexure of colon — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/30/49 | CA Hepatic flexure | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/25/, 1949 *to* 11/2/, 1949 *that I last saw the deceased alive on* 11/2/, 1949, *and that death occurred at* 6.15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas W. May M. D. | Mercy Hosp | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | New Cathedral Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

46E

PLEASE WRITE PLAINLY. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79518

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 170

Registered No. G 79518

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katherine Shefels(nee Lochstampfor)

2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6005 York Road
c. Length of stay in Baltimore: 45 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-48
D. STREET ADDRESS (If rural, give location): 6005 York Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widow | Nov.5,1864 | 84 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Butler,Balto.Co., Md. | |

13. FATHER'S NAME: Jacob Lochstampfor

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | - | - | Mrs.Ester Rasch | 6005 York Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Bronchopneumonia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Breast,Right with generalized metastases

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24-, 19 49, *to* 11-2-, 19 49, *that I last saw the deceased alive on* 11-2- 19 49 *and that death occurred at* 9:45P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas. B. Carr Jr. M.D. | 6007 York Road | 11-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-5-49 | Black Rock | Butler,Balto.Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-3-49 | Huntington Williams, MD | Landon M.Brooks- | Sparks,Md. |

VS 150

50 -

If this certificate is incorrect in any particular, please write the cause of death clearly and correct age is especially important. Physician

G79519

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Prov. 1

G79519

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Harry L. Thompson.

2. DATE OF DEATH: Nov 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3325 Beech Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3325 Beech Ave

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3325 Beech Ave. 13-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Aug 30 1894 | 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert L. Thompson

14. MOTHER'S MAIDEN NAME: Barbara A. Rotten

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-09-2879

17. INFORMANT: Mr. LeRoy Thompson ADDRESS: 3325 Beech Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 2 hrs. |
| DUE TO (B) | Hypertensive C V D. | ?. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2, 1949 *to* 11-2, 1949 *that I last saw the deceased alive on* 11-2, 1949 *and that death occurred at* 9:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Laurence J. Chumanch M. D.

23B. ADDRESS: 3711 Falls Rd.

23C. DATE SIGNED: 11-3-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 4, 1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Belair Road Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Austin E. Donovan ADDRESS: 3818 Roland Ave

937

Please write the cause of death clearly and correct age is especially important. Physician:

G79520

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 438.0 G79520

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Othal Nyblette

2. DATE OF DEATH: 11/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 14 Yrs. [illegible] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 13 W. Preston St 11-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 23 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanic | Air conditioning | Minn. | U.S.A. |

13. FATHER'S NAME: Chris Nyblette

14. MOTHER'S MAIDEN NAME: Dorothy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Subacute bacterial end. carditis | 1 week ? |
| DUE TO (B) | Bronchial Pneumonia | 1 week |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (Inside, in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/27 19 49 *to* 11/3 19 49, *that I last saw the deceased alive on* 11/3 19 49, *and that death occurred at* 5:35 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Richard Frank M. D. | Mercy Hosp | 11/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | St. Peters | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Von Cook Inc. | 127 St. Paul St. |

VS 150

91a

Please write clearly and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79521

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79521

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RUDOLPH RICHARD KOHLS

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3227 Abell Ave.
c. Length of stay in Baltimore: 45 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3227 Abell Ave. 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | July 10, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baker | Self | Germany | |

13. FATHER'S NAME: (Unknown) Kohls

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Mrs Herman Kohls, 3227 Abell Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio-Sclerotic Cardio-Vascular Renal Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/31, 1947 *to* 11/3, 1949 *that I last saw the deceased alive on* 11/3, 1949 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Isaac S. Blum M. D.

23B. ADDRESS: 1115 N. Calvert St.

23C. DATE SIGNED: 11/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/5/49

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Rosedale, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR / ADDRESS: William Cook, Inc., 1217 St. Paul St.

VS 150

131a

79522

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1949-8 Registered No. 679522

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DORA DANIELS

2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 Madison Ave.

c. Length of stay in Baltimore: 35 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 803 Madison Ave. 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Oct 2, 1886 | 63 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Virginia | |

13. FATHER'S NAME: (Unknown) Ringstaff

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Mr Roy Jackson, | 3400 Shellsum Court |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO Primary site undetermined

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 18, 1949, *to* Nov. 3, 1949, *that I last saw the deceased alive on* Oct. 30, 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Sidney R. Gehlert M. D. | 4700 Pimmington Ave. | 11/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | Glen Haven | Glen Burnie, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

55E

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G79523 G79523

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HYMAN M. GROSS
2. DATE OF DEATH: 11-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3820 Reistertown Rd
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3820 Reistertown Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Simon Bernstein Co | Poland | |

13. FATHER'S NAME: Jenchum
14. MOTHER'S MAIDEN NAME: Hannah

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mary Gross | 3820 Reist Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — (INTERVAL BETWEEN ONSET AND DEATH) Died in sleep

DUE TO

(B) Coronary artery disease — 5 years

DUE TO

(C) Arterio-sclerosis with enl'g'd heart — 8 years

(x-ray chest + E K G Nov. Oct 24, 1949 Sinai Hospital)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1946 *to* Nov 2, 1949, *that I last saw the deceased alive on* Nov 2, 1949, *and that death occurred at* 2 PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jack Cohen M.D. M. D. | 1804 Eutaw Place | 11/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-4-49 | Bnai Israel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

PLEASE WRITE PLAINLY. If any item cannot be answered, write unknown. Please see that the cause of death is correct and legibly. Physicians: please write the cause of death clearly and legibly. age is especially important.

94a

G79:524 ✓ G79:524

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 31 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ida Hurdus

2. DATE OF DEATH Nov. 3 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2476 Shirley Ave.

c. Length of stay in Baltimore 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2476 Shirley Ave. 15-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Rogan | Unknow |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Celia Kaplan | 6516 Park Heights Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — 1 day

DUE TO

ANTECEDENT CAUSES

(B) Arterio Sclerosis — 5 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertension

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1945 19__ *to* Nov 3 1949 *that I last saw the deceased alive on* Nov 3 1949 *and that death occurred at* 10:38 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm J Baylus M. D. | 7040 Eulaw Pl | 11/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 4, 1949 | Beth L. New York City | New York City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

83a

*Physicians: please write the cause of death clearly and legibly. Especially important. Physicians: please write the cause of death clearly and legibly.*

G79525 Buhner G79525

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 330

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Oscar Buhner

2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: MD. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, MD. 26

c. Length of stay in Baltimore: 7 4 yrs. (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): 6506 Cleveland Ave. 6

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M | Jan. 11, 1870 | 79 78 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Buhner

14. MOTHER'S MAIDEN NAME: Eliz. Fleischman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Theresa Gunkel ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/27, 1949 to 11/2, 1949 that I last saw the deceased alive on 11/2 1949, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Ronald L. Deaton M. D.

23B. ADDRESS: Church Home

23C. DATE SIGNED: 11/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 5, 1949

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Roland L. Fisher ADDRESS: 2112 Dundalk Ave.

VS 150

83a

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G79526

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Dr. 1

G79526

Registered No.

1. NAME OF DECEASED (Type or Print): Theresa M. Smith (Theresa M.Smith)

2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2222 E. Lanvale St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2222 E.Lanvale Street 8-0 r

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Aug. 15th., 1892 | 57 | 2 | 17 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Christian Miller
14. MOTHER'S MAIDEN NAME: Mary Kruetzer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
16. (If yes, give war or dates of service)
SOCIAL SECURITY NO.
17. INFORMANT: Mr. Albert C.Smith--2222 E.Lanvale St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Disease | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: Nov. 2 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II-5-49 | Holy Redeemer Cemetery | Belair Road, Balto: Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George J. Ruth, Inc. ADDRESS: I735 Harford Avenue

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

G79527

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

G79527

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MARY FREEMAN

2. DATE OF DEATH November 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

C. Length of stay in Baltimore 20 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 911 Hillen Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | Single | Sept. 19. 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Private | Georgia | U.S.A. |

13. FATHER'S NAME Archie Freeman

14. MOTHER'S MAIDEN NAME Jessie Anthony

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | James Reed 9II Hillen St | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemorrhage | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Nov. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-5-49 | Mt. Calvary cem | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR, ADDRESS |
|---|---|---|
| | Huntington Williams, M.D. | Elroy O. Wilson 1600 Brantley |

VS 151

832a

PLEASE WRITE PLAINLY, with ink, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79528

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 93 G79528

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Missouri Griffin

2. DATE OF DEATH: Nov. 3. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 267 Colvin Street

c. Length of stay in Baltimore: 9 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 267 Colvin Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | Sept. 19. 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Private | Virginia | U.S.A. |

13. FATHER'S NAME: John Payne

14. MOTHER'S MAIDEN NAME: Rosie Davis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | Lillian Griffin | 267 Colvin Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) severe anemia

DUE TO

(C) malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* 3 Nov, 1949, *that I last saw the deceased alive on* 2 Nov, 1949 *and that death occurred at* 10:15 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. E. Burwell M. D. | 121 Biggath St. | 11-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 5. 1949 | Mt Calvery Cem. | Brooklyn A.A.Co.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Brantly Avenue |

VS 150

108

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79529

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79529

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Dorsey

2. DATE OF DEATH: II/I/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 339 Forrest Street

C. Length of stay in Baltimore: 18 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 339 Forest Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | Feb. 15. 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Unkown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Howard Dorsey — ADDRESS: 339 Forrest Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio renal disease — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

(B) Hypertension — ?

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1949 *to* Nov 1949 *that I last saw the deceased alive on* Oct 30 1949 *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. C. Burwell M. D.
23B. ADDRESS: 1 Aisquith St
23C. DATE SIGNED: 11-4-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: II/4/1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cem.
24D. LOCATION (City, town, or county) (State): Brooklyn Md.
ADDRESS
25. FUNERAL DIRECTOR: Elroy O. Wilson 1000 Brantly Ave

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

VS 150

1310

Important. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G79530

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79530

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sauer, Mr. George W

2. DATE OF DEATH: 3 Nov. 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: 57 years Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 13 East Elm Street. A.V.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | married | 20 July 1892 | 57 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Policeman | Police | Baltimore | U.S. |

13. FATHER'S NAME: Sauer, Mr George C

14. MOTHER'S MAIDEN NAME: Waldeck, Catherine

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| YES WORLD WAR I | — | Mr. George Sauer | 13 E. Elm St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio Sclerosis Generalized

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Exploratory Laparotomy for Carcinoma of Rectum — 9 days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 27 Oct 49 | Tumor of Recto Sigmoid | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 10-24, 1949 *to* 11-3, 1949 *that I last saw the deceased alive on* 3 Nov, 19 49, *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dorsey Sherburne M. D. | Church Home & Hospital | 3 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV 6 1949 | HOLY REDEEMER | 4430 BELAIR R | MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Duffel Bro | 7110 BELAIR ROAD |

VS 150

46D

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G79531
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79531
Registered No.

1. NAME OF DECEASED (Type or Print): SARAH Elizabeth CHASE
2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1627 W. FRANKLIN St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1627 W. FRANKLIN St. 19-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widow | 5-22-87 | 62 | 5 / 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Calvert County, Md. | U.S.A. |

13. FATHER'S NAME: William Duke
14. MOTHER'S MAIDEN NAME: Edith Tabbs

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No. | | |

17. INFORMANT: Jerome Chase — ADDRESS: 1517 W. Franklin St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral Hemorrhage | Several days |
| DUE TO | | |
| (B) | Cardio renal Disease | Unknown |
| DUE TO | | |
| (C) | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October 15, 1949, *to* November 2, 1949, *that I last saw the deceased alive on* 11-1-, 1949, *and that death occurred at* 4:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard H. Hunt, M. D. | 1631 W. FRANKLIN St. | 11-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 5, 1949 | Carbutus Memorial | Arbutus, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | Edmondson St. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1310

G79:32 MS—132972

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

99-8 Registered No. G79:32

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Susie Williams

2. DATE OF DEATH 10-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore 27 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 750 George St. 17-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widowed | March 15, 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: John Cratley

14. MOTHER'S MAIDEN NAME: Sophie Gibson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | | Baltimore City Hospitals Records—4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis Primary site, undertermined — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-28-49 | Intestinal obstruction, due to neoplasm | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-27- 1949 *to* 10-30- 1949, *that I last saw the deceased alive on* 10-30- 1949, *and that death occurred at* 12 midnight *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Cogan M. D. | Baltimore City Hospitals | 10-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 4, 1949 | Mt Zion Cem. | Laurel Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Arlington Williams, M.D. | Mrs Katie R. Williams | 322 N Schroeder St |

VS 150

55E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79533

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 3 ✓ Registered No. G79533

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) JOHN C. KOHLER | 2. DATE OF DEATH Nov. 3, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 810 Woodington Rd. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. |
| c. Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 2406 Calvdrton Hgts. Ave. 16-0- |
| 5. SEX male | 6. COLOR OR RACE white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married | 8. DATE OF BIRTH Nov. 20, 1869 |
| 9. AGE (In years last birthday) 79 yrs. | If Under 1 Year: Months Days; If Under 24 Hours: Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired factory mgr. | 10B. KIND OF BUSINESS OR INDUSTRY Sheet & Metal |
| 11. BIRTHPLACE (State or foreign country) Balto., Md. | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Thomas Kohler | 14. MOTHER'S MAIDEN NAME Unknown |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 212-16-8963A |
| 17. INFORMANT Mrs. Marjorie Zies | ADDRESS 810 Woodington Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 14 days |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis | 4 years |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Oct 1, 1947 *to* Nov 3, 1949 *that I last saw the deceased alive on* Nov 3, 1949 *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE C. A. Mendelis M. D. | 23B. ADDRESS 65 N Bentalou St | 23C. DATE SIGNED Nov 3-49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 11/5/49 | 24C. NAME OF CEMETERY OR CREMATORY Balto. Cem. |
| 24D. LOCATION (City, town, or county) (State) Baltimore, Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR NOV 4 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS |
| ADDRESS Balto., Md. | | |

VS 150

correct age is especially important. Physician: please write the causes of death clearly and legibly.

8.30

G79534

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

G79534

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MARY HOLBROOK

2. DATE OF DEATH: Nov. 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 903 N. Stricker St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 70 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 903 N. Stricker St 16-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | W.dowed | 5/18/1867 | 82 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Domestic | Eastern Shore, Md | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George ? | Elizabeth |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Rodger Deshields | 303 N. Stricker St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 Months

DUE TO

(B) Hypertensive Card-Vas-Disease — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug. 12, 1949 *to* Nov. 2, 1949, *that I last saw the deceased alive on* Nov. 1, 1949 *and that death occurred at* 10.00 P., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George McDonald, M. D. | 844. N. Carey St. Balt. Md. | 11/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | Mt. Auburn Cemetery | Dalto, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Chas. Hoffman | 512 N. Eutaw St. |

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

679535

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 679535

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH ALICE ECK

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1800 Ashburton St.
c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1800 Ashburton St. 15-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | divorced | June 22, 1884 | 65 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Union Bridge, Md. | |

13. FATHER'S NAME: Upton Stoner

14. MOTHER'S MAIDEN NAME: Margaret Perry

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. LaReau Seger | 1800 Ashburton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | sudden |
| DUE TO | Arteriosclerosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 1st, 1949 *to* Nov 3rd, 1949 *that I last saw the deceased alive on* Nov 4, 1949, *and that death occurred at* 6 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|---|
| [signature] | | 3033 West End | 10/[illegible]/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 11-4-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G79536 Registered No. G79536

1. NAME OF DECEASED (Type or Print): Edenfield, William A.

2. DATE OF DEATH: Nov. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 2513 Edmondson Ave. ~~Hugo's Hotel, 328 W. Camden St.~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years, last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | widowed | Jan. 1874 | 75 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Kent Island, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Emory Edenfield

14. MOTHER'S MAIDEN NAME: Anna Thawley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Charles H. Edenfield ADDRESS: 2605 List Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease with — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) probable coronary thrombosis — 12 hrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE R&O Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 1, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | Loudon Park Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79537

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79537

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | EVA B. McSHERRY |
| 2. DATE OF DEATH | Nov. 3, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2706 Roslyn Ave. |
| c. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Balto. |
| D. STREET ADDRESS (If rural, give location) | 2607 Roslyn Ave. |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widow |
| 8. DATE OF BIRTH | Sept. 17, 1881 |
| 9. AGE (In years last birthday) | 68 yrs. |
| If Under 1 Year: Months / Days | |
| If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | home |
| 11. BIRTHPLACE (State or foreign country) | A. A. Co., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | John W. Stockett |
| 14. MOTHER'S MAIDEN NAME | Monterey Jones |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT / ADDRESS | Mr. Horace L. McSherry 2607 Roslyn Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Stomach | 18 mos. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Myocarditis | 2 mo. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Jan - 16, 1948 *to* Nov 3, 1949 *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE M. D. | 23B. ADDRESS 2220 Garrison Blvd | 23C. DATE SIGNED |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 11/5/49 | 24C. NAME OF CEMETERY OR CREMATORY Lorraine Cem. |
| 24D. LOCATION (City, town, or county) (State) | Woodlawn, Maryland | |
| DATE RECEIVED BY LOCAL REGISTRAR NOV 4 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS |
| ADDRESS | Balto., Md. | |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

46B

679538

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 679538

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OTIS VENNEY

2. DATE OF DEATH November 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 108 N. Poppleton Street 18-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | married | April 5 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| plasterer | Construction | Virginia | U.S.A. |

13. FATHER'S NAME
Unknown

14. MOTHER'S MAIDEN NAME
Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Fannie Veaney | 108 N. Poppleton St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Nov. 4, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Mt. Calvary Cemet. | Cedar Hill Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, MD | A. Halstead | 918 Druid Hill Ave. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

MS--133074
G79539

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

171 G79539 Registered No.

1. NAME OF DECEASED (Type or Print): Minnie Chase

2. DATE OF DEATH: 11-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 818 Tyson St. 11-03

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July 4, 1882
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry
14. MOTHER'S MAIDEN NAME: Katie Sampson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis
DUE TO
(B) Carcinoma of Cervix

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pyonephrosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31-, 1949, *to* 11-3-, 1949, *that I last saw the deceased alive on* 11-3-, 1949, *and that death occurred at* 1:40 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: H. B. Thorpe M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 7, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion
24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home (ADDRESS)

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1631 Druid Hill Ave
48a

BIRTH NO. 79540

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79540

1. NAME OF DECEASED (Type or Print): CHARLES [illegible] SMITH
2. DATE OF DEATH: 11/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23
D. STREET ADDRESS (If rural, give location): 3038 Gannon Ave. 25-37

5. SEX: M
6. COLOR OR RACE: C
7. ~~SINGLE~~ MARRIED, ~~WIDOWED~~ ~~DIVORCED~~ (Specify):
8. DATE OF BIRTH: 1899
9. AGE (In years last birthday): 50 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Horseman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Tilly Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 218-09-2978
17. INFORMANT: Beatrice Smith ADDRESS: (same) - Life

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia - Aspiration
DUE TO
ANTECEDENT CAUSES
(B) Called Unknown
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/21 19 49 *to* 11/1 19 49, *that I last saw the deceased alive on* 11/1 19 49 *and that death occurred at* 9 45 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nicholas Maltz M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 11/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: 1631 Druid Hill Ave

VS 150

83B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MS—132770
679-41

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 1

Registered No. 679-41

1. NAME OF DECEASED (Type or Print): James Abrams

2. DATE OF DEATH: 11-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 518 Sanford Place 14-03

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Separated | Sept. 19, 1893 | 56 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Abrams ?

14. MOTHER'S MAIDEN NAME: ? ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Records-- ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Uremia

DUE TO

(C) Generalized and Cerebral Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-20- , 1949, *to* 11-1- , 1949, *that I last saw the deceased alive on* 11-1- 1949, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. S. Dogan M. D.

23B. ADDRESS: 4940 Eastern Ave.

23C. DATE SIGNED: 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 5, 1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home

ADDRESS: 1631 Druid Hill Ave

83a

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C79542

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C79542

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Green

2. DATE OF DEATH: November 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 11 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-03
D STREET ADDRESS (If rural, give location) 404 W. Biddle St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widowed | ?-?-78 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Daniel Quickley

14. MOTHER'S MAIDEN NAME: Louisa Curtis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Digitalis intoxication | 3d |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive arteriosclerotic cardiovascular disease | 3 yr |
| | (C) Arteriolonephrosclerosis | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-31, 1949, *to* 11-2, 1949 *that I last saw the deceased alive on* 11-2, 1949, *and that death occurred at* 10 50 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David E. Rogers M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 6, 1949 | Mt. Zion | Long Green, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. 1310 |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:543

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79:543

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theresa Weaver

2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St Joseph's Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1421 N. Milton Ave 8-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 29-1873 | 76 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. Md. | |

13. FATHER'S NAME: Francis Hattenreich

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Charles F. Weaver 1421 N. Milton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 11/3/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-5-49 | Holy Redeemer | Belair Rd - Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | John C. Miller Inc - 2435 E. Oliver St |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

93D

BIRTH NO. 79:54

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 Registered No. G79:54

1. NAME OF DECEASED (Type or Print): ERNA A. HULLETT
2. DATE OF DEATH: Nov 3. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 Lemmon St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 1604 Lemmon St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 6/6/1918 | 31 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Packer | Paper Bag Co | Baltimore Md | |

13. FATHER'S NAME: John P. Franz
14. MOTHER'S MAIDEN NAME: Catherine Harmon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 214-22-0901 | Margaret Spencer | 1604 Lemmon St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) carcinoma, cervix uteri, metastatic — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1948, *to* Nov 3, 1949, *that I last saw the deceased alive on* Nov 2, 1949, *and that death occurred at* 1:00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Nathan Rosenau, M. D. | 23B. ADDRESS: 206 S. Gilmor St. | 23C. DATE SIGNED: 11-4-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 7 1949 | London Park | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. A. & B. M. Welsh — ADDRESS: Arnold & Brooklyn Md

VS 150

48a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:545

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 G79:545
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROY C. GORDON

2. DATE OF DEATH: November 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pimlico Race Track

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3403 Avondale Avenue 7-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Aug. 19, 1890 | 59 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Patrol Judge + Starting Barrier | Race Business | Sheepshead Bay, N. Y. | |

13. FATHER'S NAME: Roy Allen Gordon

14. MOTHER'S MAIDEN NAME: Katherine ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes World War I | 432-01-0193 | Mrs R.C. Gordon | 3403 Avondale Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary arteriosclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R S Fisher, M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: Nov. 3, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 7/49 | Druid Ridge | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Thurston Williams M.D. | Loring Byers | 5605 Pk Heights Ave. |

VS 151

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79546 G79546

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 69 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis D. Diette

2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balt. General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ecleston
D. STREET ADDRESS (If rural, give location): 4012 Belle Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 year: Months | Days | If Under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Sept 17/92 | 57 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supt of Country Estate | | Michigan | |

13. FATHER'S NAME: Louis D. Diette

14. MOTHER'S MAIDEN NAME: Cordelia Isabella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Louis D. Diette ADDRESS: 519 W Broad St Falls Church Va

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Infectious Hepatitis | About 30 days |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/11, 1949, to 11/2, 1949, *that I last saw the deceased alive on* 11/2, 1949, *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arlyn H Wood M. D. | West Balt. General Hosp | 11/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 5/49 | St. Elizabeth Catholic Cem | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 4 1949 | Immediate Interment Williams, M.D. | Loring Byers 5005 Pk Heights Ave |

VS 150

32a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-133139 G79547

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79547 Registered No.

1. NAME OF DECEASED (Type or Print): George Weatherstine

2. DATE OF DEATH: 11-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-10
D. STREET ADDRESS (If rural, give location): 313 S.(?) Baltimore St. Bonaldy St - City Infirmary

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: Oct. 16-1872
9. AGE (In years last birthday): 77 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown.
14. MOTHER'S MAIDEN NAME: Barbara Unknown.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Baltimore City Hospitals records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2 , 1949, *to* 11-3 , 1949 *that I last saw the deceased alive on* 11-3 , 1949, *and that death occurred at* 7.10 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Rozer M. D.
23B. ADDRESS: Baltimore City Hospitals 4940 Eastern Avenue
23C. DATE SIGNED: 11-3-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/8/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Frederick Rd. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: Lester Williams M.D.
25. FUNERAL DIRECTOR: John J. Connelly.
ADDRESS: Balto 24, Md.

VS 150

8 30

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79548 BALTIMORE CITY HEALTH DEPARTMENT G79548

BIRTH NO. **CERTIFICATE OF DEATH** 151 Registered No.

1. NAME OF DECEASED (Type or Print): Edward C. Dull
2. DATE OF DEATH: 11-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3445 Greenmount Ave
c. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3445 Greenmount Ave 9 1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months: Days | If Under 24 Hours: Hours: Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 17, 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Time Keeper | Construction | Virginia | |

13. FATHER'S NAME: Edward E. Dull
14. MOTHER'S MAIDEN NAME: Ell Powell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 224-07-8497 | Mrs Margaret E. Dull | 3445 Greenmount Ave |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Stomach | 2 Y's. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| May 1948 Aug. 1949 | Carcinoma of pyloric end of stomach | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 1948, *to* Nov. 2, 1949, *that I last saw the deceased alive on* Nov. 1, 1949, *and that death occurred at* 11.25A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lloyd E. Taylor M. D. | 3902 Greenmount Ave. | Nov. 3, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-5-49 | Meadow Branch | West Minister Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Hunterton Williams, M.D. | John A. Moran | 3000 E. Balt. St. |

VS 150

46 R

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79549

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79549 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rhoda Roach

2. DATE OF DEATH: 11-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4212 Parkmont Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 614 E. 41st St 9 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | 11-25-1860 | 88 | 11 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | |

13. FATHER'S NAME: John L. Gough

14. MOTHER'S MAIDEN NAME: Hester Q. Mortgage

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Geo. M. Dewlin | 614 E. 41st St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO Generalized Arteriosclerosis — 10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan ____, 1946, *to* Nov. 3, 1949, *that I last saw the deceased alive on* Nov 2 1949 *and that death occurred at* 4.35A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lloyd E. Saylor M.D. | 3902 Greenmount Ave. | Nov. 3, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-5-49 | Chesterfield | Centerville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | John H. Moran | 3000 E. Balt. St. |

VS 150

937

Dr. Melvin Borden
2030 W Fayette St

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. G79530 — Registered No. 1 G79530

1. NAME OF DECEASED (Type or Print): Joseph F. Ellebrock
2. DATE OF DEATH: Nov. 3 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 9-08; D. STREET ADDRESS (If rural, give location) 1018 Bonaparte St.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunnyside Home
c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year: Months, Days; If under 24 hours: Hours, Min.) |
|---|---|---|---|---|
| male | white | widowed | Sept 22-1866 | 83 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Richmond, Va. | |

13. FATHER'S NAME: August L. Ellebrock
14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| | | Mr. A. J. Ellebrock - 304 E 29th |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis & myocardial degeneration — (INTERVAL BETWEEN ONSET AND DEATH) years

DUE TO

(B) Generalized Arteriosclerosis — years

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from August 10, 1949, to November 3, 1949, that I last saw the deceased alive on November 2, 1949, and that death occurred at 5A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M.D. | 2030 W. Fayette St | November 3 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 11/5/49 | Holy Redeemer | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | L. J. Luck | 5505 Harford Rd. 14 |

VS 150

92D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79551 ✓ 199-8 G79551

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. X

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALBERT M. MERKLE

2. DATE OF DEATH: November 3, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 2616 W. Woodwell Rd.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | December 6, 1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | Canton R.R. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: George Merkle

14. MOTHER'S MAIDEN NAME: Margaret Zimmerman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | U.S. Army | 218-01-1432 | Margaret Hoffman | 2616 W. Woodwell Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Disseminated Carcinomatosis, primary site undetermined

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-6-, 19 49, *to* 11-3-, 19 49, *that I last saw the deceased alive on* 11-3, 19 49, *and that death occurred at* 12:30 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M.D. | Sinai Hospital | 11-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 7, 1949 | Oak Lawn Cemetery | 7225 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Evelyn Williams, M.D. | Charles S. Zeiler | 901 S. Conkling St. |

NOV 8 150

55E

correct age is especially important. Physicians: please write the cause of death in terms of disease, and not in terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia.

G79552

G79552

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 17

Registered No.

1. NAME OF DECEASED (Type or Print): MILDRED MARIE BOLAND

2. DATE OF DEATH: November 2, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 800 N. Streeper St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 800 N. Streeper St. 7-21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | April 15, 1906 | 43 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William F. Healey

14. MOTHER'S MAIDEN NAME: Margaret Englebach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: J. Carroll Boland ADDRESS: 800 N. Streeper St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Carcinoma of Left Breast — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Epileptic attacks - metastasis of carcinoma to brain

INTERVAL BETWEEN ONSET AND DEATH: Oct 16/49

19A. DATE OF OPERATION: Jan 29/49

19B. MAJOR FINDINGS OF OPERATION: carcinoma of Left Breast

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 16, 1949, *to* Nov 2, 1949, *that I last saw the deceased alive on* Nov 2, 1949, *and that death occurred at* 9:24 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis F. Kummerow M. D.

23B. ADDRESS: 722 W. Lenwood Ave

23C. DATE SIGNED: Nov 4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/5/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.

24D. LOCATION (City, town, or county) (State): 4300 Old Fred'k Rd. Balto.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: Pennington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

50

correct age is especially important. Physicians: please write the names of death county and registry.

G79553

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79553

BIRTH NO. 150 Registered No.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH DEINLEIN

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2807 Jefferson St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 70 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2807 Jefferson St. 6-21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Jan. 24, 1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Philip Staab

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Margaret M. Deinlein ADDRESS: 2807 Jefferson St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) ARTERIOSCLEROSIS | 10 YEARS |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) CHR. INT. NEPHRITIS - | 3 YRS. |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) ACUTE MYOCARDIAL FAILURE | 1 DAY. |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV 1 *, 19*49*, to* NOV 3 *, 19*49*, that I last saw the deceased alive on* NOV 3 *, 19*49*, and that death occurred at* 3 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: James J Kavanagh M.D. M. D. | 23B. ADDRESS: 304 W Fredrick St | 23C. DATE SIGNED: 11-4-49.

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 7, 1949 | Holy Redeemer Cem. | 4430 Belair Rd. Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE: Evelyn Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

NOV 4 1949

VS/150

1310

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79552

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G79552 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Webster Maddux Kefauver

2. DATE OF DEATH: Nov-3-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2620 St. Paul Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2620 St Paul St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Aug-19-1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | retired | Bells Md. | U.S. |

13. FATHER'S NAME: Charles Mason Kefauver

14. MOTHER'S MAIDEN NAME: Lizzie Saddess

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | W. M. Kefauver | (Son) dead |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) None

DUE TO

(C) None

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug 1, 1949, *to* Nov. 3, 1949 *that I last saw the deceased alive on* Nov. 3, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank N. Ogden. M. D. | 2701 N. Calvert St. | Nov. 4, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Green Mount | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Stewart Morris | Balto. |

VS 150

927

correct age is especially important. Physicians: please write the words or death clearly and legibly.

4-0a G79555 ✓ G79555

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 46 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Myrtle Simms

2. DATE OF DEATH: NOV 2- 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1530 N. Eden St 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | 9-5-06 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Simms | Estella Dorsey |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Henry Jenkins | 1530 N. Eden St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Nephrosclerosis and

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
For-DR. DAVIS
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4-0a 19__, *to* 11-2-, 1949 *that I last saw the deceased alive on* ____ 19__ *and that death occurred at* 6 30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Lukens M.D. | | 11-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-6-49 | Mt. Calvary | A. A. County, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Joseph B. Locke, Jr. | 1304 N. Central Ave |

VS 150

Medical Ex Case to be approved

131a

G79556 ✓ X G79556

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 49-23737 CERTIFICATE OF DEATH 776 Registered No.

1. NAME OF DECEASED (Type or Print): Melissa Kinsey

2. DATE OF DEATH: 11-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2025 W. Fayette St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk - 22, Rural
D. STREET ADDRESS (If rural, give location): 8152 Bullneck Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | | 11-3-49 | | | 15 / 20 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Cyril Delp Kinsey

14. MOTHER'S MAIDEN NAME: Juanita Ernestine Caye

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 3, 1949 *to* Nov 3, 1949 *that I last saw the deceased alive on* Nov 3, 1949 *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John K Mallen M.D. M. D. | Bon Secours Hosp. Baltimore, Md. | Nov 4, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-4-49 | New Cathedral | Frederick Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Thos. J. Kenny Inc. | 1600 Hollins St |

VS 150

159

correct age is especially important. Physicians: please write the causes of death plainly and legibly.

G79557 ✓ G79557

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 3 1 Registered No.

1. NAME OF DECEASED (Type or Print): ELLA ROSENTHAL

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 800 W. North Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 800 W. North Ave. 1202

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | 1865 | about 84 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Baltimore, Md. | |

13. FATHER'S NAME: Louis Rosenthal

14. MOTHER'S MAIDEN NAME: - Reis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| - | - | Mr. John L. Dowell | Pikesville, Md. 133 Brightside Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-vascular accident, brain hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 days

DUE TO

(B) Hypertension — sev yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| - m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan, 19 49, Oct. 3, 1949, *that I last saw the deceased alive on* Oct. 3, 19 49 *and that death occurred at* 11:00 a.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2431 MARYLAND AVE | 11/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-4-49 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93 D

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G79558

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54 Registered No. G79558

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth M. Schreiber
2. DATE OF DEATH: 11/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 411 Pittman Place
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 411 Pittman Place 12-05

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 5/15/1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Va | |

13. FATHER'S NAME: John Fiddon
14. MOTHER'S MAIDEN NAME: Mary Mumma

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Rudolph Schreiber | 411 Pittman Place |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Rectum — INTERVAL BETWEEN ONSET AND DEATH: 16 mo.
DUE TO Colostomy 4/12/48
(B) Hemorrhoids
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/12/48 | Carcinoma of Rectum | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* August, 1948 *to* 11/3, 1949 *that I last saw the deceased alive on* 11/2, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward [illegible] M. D. | 2020 N. Charles St. | 11/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/5/49 | Western | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 1217 St. Paul St. |

VS 150

467

G79559

BALTIMORE CITY HEALTH DEPARTMENT 193

# CERTIFICATE OF DEATH

Registered No. G79559

BIRTH NO. VADIE

1. NAME OF DECEASED (Type or Print): Vadie Mc Minn

2. DATE OF DEATH: 2 Nov. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 823 Park Avenue 11-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | Feb. 23, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife Cook | arcade Cleaners | Tennessee | US. |

13. FATHER'S NAME: Houston Hamler

14. MOTHER'S MAIDEN NAME: Rowena Hamler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 454-22-6344 | Patient | Roy Mc Minn 823 Park Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain stem thrombosis + edema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Following removal of [redacted]

DUE TO acoustic neuroma, left

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 31 October 1949 | Left acoustic neuroma | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 20 Oct, 1949, *to* 2 Nov, 1949, *that I last saw the deceased alive on* 2 Nov, 1949, *and that death occurred at* 6 10 P M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jose A. Alvarez-de Choudens M. D. | University Hospital | 3 Nov 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/5/49 | Woodlawn Mem. Cemetery | Durham, N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 4 1949 | Huntington Williams, M.D. | Wm. Cook, Inc. | 1217 St Paul St |

VS 150

56D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79560 ✓X G79560

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

150 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BENJAMIN LOUIS HEMBY

2. DATE OF DEATH Nov. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore 35 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE NC B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greenville

D. STREET ADDRESS (If rural, give location) 206 Tenth St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 5/7/96 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Seafarer | NC | |

13. FATHER'S NAME Henry C. Hemby

14. MOTHER'S MAIDEN NAME Mary E. Baker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | Unknown | Mrs. Zilphia Rotroff, 206 E. 10th Street Greenville, N.C. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of esophagus with metastasis to mediastinal nodes, liver, kidneys and brain — Interval between onset and death: Duration unknown

DUE TO

(B) Abscess of right lung — Interval between onset and death: Duration unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Sept. 30, 1949, *to* Nov. 4, 1949, *that I last saw the deceased alive on* Nov. 4, 1949, *and that death occurred at* 10:40 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11/ / 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| removal | 11/5/49 | Washington | Washington, North Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 4 1949 | Funeral Director Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

46a

G79561

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 1553 Registered No. G79561 15944-7

1. NAME OF DECEASED (Type or Print): Mrs. Catherine Griffin
2. DATE OF DEATH: 11-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 31. N. Monastery Ave 20-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 2-28-1874
9. AGE (In years last birthday): 75 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Maurice Griffin
14. MOTHER'S MAIDEN NAME: Julia Fitzgerald

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Miss Agnes R. Griffin — ADDRESS: 133 S. Hilton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Annular Carcinoma of Descending Colon
DUE TO
ANTECEDENT CAUSES
(B) with Metastases to Liver
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive C-V Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 10-31-49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Colon with Metastases
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-27, 1949 to 11-3, 1949 that I last saw the deceased alive on 11-3, 1949, and that death occurred at 4 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Stephen V. Padussis, M.D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 5/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Wilkes — ADDRESS: 4101 Edmondson Ave

VS 150

46E

correct age is especially important. Physicians: please write the causes of death very carefully and legibly.

G79562

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916.0

Registered No. G79562

1. NAME OF DECEASED (Type or Print): Gladys (Cariher) Kernan — N-968.0

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5910 Greenhill Ave. 26-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Feb. 15, 1918 | 31 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | | Penn. | |

13. FATHER'S NAME: Cariher

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ EDNA PEARL PHILLIPS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (husband) ADDRESS: Vincent J. Kernan, 5910 Greenhill Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(I) (A) Asphyxiation due to

~~pneu~~ inhalation of illuminating

(B) gas. (carbon monoxide poisoning)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

(II) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Second floor, 5910 Greenhill Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 3, 1949 5:30 A.m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Gas stove exploded 26-01

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Geo. G. Merrill, M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 7/49

24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Memorial Pk.

24D. LOCATION (City, town, or county) (State): Dorsy, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 4 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry F. Lintz

ADDRESS: 4101 Edmondson Ave.

178a

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79563 ✓ G79563

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. [redacted]

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edgar Edward Ivvers

2. DATE OF DEATH: 11/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1633 Laurens St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 1633 Laurens St. 16-03

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | W | 4/7/[illegible] | 73 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Porter | | Balto. | U. S. A. |

13. FATHER'S NAME: David Ivvers

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 217-03-6691 | [illegible] | 1633 Laurens St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — Unknown

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8-17, 1945, *to* 11-2, 1949, *that I last saw the deceased alive on* 11-2-1949, *and that death occurred at* 10 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank A. Saunders M. D. | 1029 N. Stricker St. | 11-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | New Cathedral | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 5 1949 | Lunterington Williams, M.D. | [illegible] Nelson | 1003 N. Patterson St. |

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G79564 ✓x G79564

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 581

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) [redacted] Katherine Hann

2. DATE OF DEATH 11-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Squares Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Reisterstown
D. STREET ADDRESS (If rural, give location) —

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Married | 12-9-1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jackson Eaton

14. MOTHER'S MAIDEN NAME Hook

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No —

16. SOCIAL SECURITY NO None

17. INFORMANT Corman Hann ADDRESS Reisterstown Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepato Renal Syndrome

DUE TO

(B) Cirrhosis of Liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 11/1/49

19B. MAJOR FINDINGS OF OPERATION Cirrhosis of Liver

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24, 1949 *to* 11-3, 1949 *that I last saw the deceased alive on* 11-3, 1949 *and that death occurred at* 8 20 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE M R Lowndes M.D.

23B. ADDRESS 1 Rex Ct Md

23C. DATE SIGNED 11/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Nov 6-1949

24C. NAME OF CEMETERY OR CREMATORY Reisterstown Meth. Cem.

24D. LOCATION (City, town, or county) Reisterstown (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 5 1949

REGISTRAR'S SIGNATURE Lexington Williams, M.D.

25. FUNERAL DIRECTOR Wm. Berryman & Sons ADDRESS Reisterstown, Md.

VS 150

1240

G79565 — G79565

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH -60

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Myrtle Isabel Brown

2. DATE OF DEATH: 11-4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Women's Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital For Women of Md.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown. Md.
D. STREET ADDRESS (If rural, give location): 635 Main St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | 9/23/25 | 24 | 1 | 15 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore Co. Md | U S |

13. FATHER'S NAME: Joseph Brown

14. MOTHER'S MAIDEN NAME: Anna Gill

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | | 219-22-3595 | Mother | 635 Main St. Reisterstown, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Diabetic Acidosis | 36 hrs. |
| DUE TO (B) | Diabetes Mellitus | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Glomerulo Nephritis | 22 yrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 2 19 49 *to* Nov 4, 19 49, *that I last saw the deceased alive on* Nov 4 19 49, *and that death occurred at* 3 30 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John R. Smith Jr. M. D. | Hosp. for Women of Md. Balto Md | 11-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Nov. 7-1949 | Druid Ridge Cemetery | Pikesville | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 | [illegible] | Wm Bergman & Sons | Reisterstown, Md. |

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79:566 BALTIMORE CITY HEALTH DEPARTMENT G79:566

BIRTH NO. CERTIFICATE OF DEATH 331 Registered No.

1. NAME OF DECEASED (Type or Print) JOHN SKRUPSKI
2. DATE OF DEATH 11/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore UNK. YRS. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALT.
D. STREET ADDRESS (If rural, give location) 318 S. BROADWAY 2-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | M | JUNE 1888 | 61 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL CONTRACTOR
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) POLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH SKRUPSKI
14. MOTHER'S MAIDEN NAME JULIA DROZDOWSKA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) UNK (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Miss HELENE SKRUPSKI ADDRESS 326 HAWTHORNE RD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral vascular accident | 5 DAYS |
| DUE TO | (B) Cerebral arteriosclerosis & hypertension | YRS. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/30, 1949 *to* 11/3, 1949, *that I last saw the deceased alive on* 11/3, 1949, *and that death occurred at* 7:55 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Henry Charles Gronlund M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried
24B. DATE Nov. 7/49
24C. NAME OF CEMETERY OR CREMATORY Holy Cross
24D. LOCATION (City, town, or county) (State) Baltimore

DATE RECEIVED BY LOCAL REGISTRAR NOV 5 1949
REGISTRAR'S SIGNATURE [illegible]
25. FUNERAL DIRECTOR Fred W. Orazewski ADDRESS 1930 Eastern Ave 82a

VS 150

BIRTH NO. 679:617

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 679:617

1. NAME OF DECEASED (Type or Print): SARAH GOODMAN CAPLAN

2. DATE OF DEATH: November 4,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4004 Maine Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4004 Maine Avenue 15 0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months Days | If under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | WIDOWED | April 7,1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md. | USA |

13. FATHER'S NAME: Emanuel Goodman

14. MOTHER'S MAIDEN NAME: Kate Lewyt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Etta Baum | 4004 Maine Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9-21-49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diabetes - arteriosclerosis

DUE TO

(C) Chr. coronary insuff

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING I

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sep 21, 1949 *to* Nov 4, 1949 *that I last saw the deceased alive on* Nov 4, 1949 *and that death occurred at* 7.30 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Bernard Cohen M. D. | [illegible] | 11-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-6-49 | Balto. Hebrew | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | [illegible] for [illegible] M.D. | Sol. Levinson & Bros. | 1124-26 W North Ave |

VS 150

61

G79568

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79568 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Trixie Lucille Feldman

2. DATE OF DEATH: November 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2425 Eutaw Place

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 30 yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 2425 Eutaw Place 13-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Dec 6, 1897 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Augusta Ga

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Emile Rubinstein

14. MOTHER'S MAIDEN NAME: Mamie Skalowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dr Maurice Feldman ADDRESS: 2425 Eutaw Place

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary occlusion | 2 hrs |
| DUE TO | | |
| (B) | Coronary sclerosis | ? |
| DUE TO | | |
| (C) | Hypertension CVD | ? |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 19[illegible] *to* Nov 3, 19[illegible] *that I last saw the deceased alive on* Nov 3, 19[illegible], *and that death occurred at* 3 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.

23B. ADDRESS: 2407 Eutaw Place

23C. DATE SIGNED: Nov 4, 19[illegible]

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 6, 1949

24C. NAME OF CEMETERY OR CREMATORY: Cheb Shalom Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: [illegible] for Williams, MD

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North Ave

VS 150

93D

679569

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679569

BIRTH NO. Wo. 0 Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Margaret YEWELL

2. DATE OF DEATH 11/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. -30 2/102

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1150 Nanticoke St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | WIDOWED | Feb. 20, 1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fredericks, MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Houck

14. MOTHER'S MAIDEN NAME Hattie Phebus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Mrs. Ada Biederbeck ADDRESS (Same)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Bronchopneumonia — 2 days

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION None

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/22, 19 49 *to* 11/3, 19 49 *that I last saw the deceased alive on* 11/3, 19 49 *and that death occurred at* 7:30 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE Robert E. Lyon M. D.

23B. ADDRESS Church Home Hosp.

23C. DATE SIGNED 11/3/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | London Park | 3801 Frederick Ave |

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR John J. Lowandes Son ADDRESS 2401 Eliza St.

937

VS 150

G79570 ✓ G79570

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Eva Adomatis
2. DATE OF DEATH: 11/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2008 W. Fayette St.
C. Length of stay in Baltimore: Yrs. 50 Mos. Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1834 Dover St. 19-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | 9/8/1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Work | at Home | Lithuania | USA |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs Edward J. Pitzinger 2006 W Fayette St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 17, 1949 *to* Nov 4, 1949, *that I last saw the deceased alive on* Nov 4, 1949, *and that death occurred at* 12 M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert Scognatta M. D. | 1724 W. Lowland St | 10/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Holy Redeemer | Belair Rd Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 5 1949 | | John J. Cowan & Son 901 Hollins St. |

VS 150

83a

CERTIFICATE CORRECTED 11-10-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79571 BIRTH NO. 450 Registered No. 179571

1. NAME OF DECEASED (Type or Print): REGINA RYAN

2. DATE OF DEATH: Nov. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4734 ~~Amberley Rd.~~ Amberley Ave.
c. Length of stay in Baltimore: 65 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2205 Booth St. 2004

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Dec. 20, ~~1880~~ 1881
9. AGE (In years last birthday): 07 ~~68~~ yrs.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Sylvester Hergenroeder
14. MOTHER'S MAIDEN NAME: Catherine Hensler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): –
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Lester Ryan ADDRESS: 4734 Amberley Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerosis, general | 1½ yrs. |
| DUE TO (B) | High blood pressure, benign | 1½ yrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Diabetes mellitus. | 7 yrs. |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/17/48 19__, *to* 11/4/49, 19__, *that I last saw the deceased alive on* 11/1/49, 19__, *and that death occurred at* 8:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Gilbert E. Rudman M. D.
23B. ADDRESS: 2517 W. Balto. St.
23C. DATE SIGNED: 11/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/7/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Lucy Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

61

Correct age is especially important. Physicians, please answer all questions.

G79572 ✓ G79572

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

175 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Tinsley, Virginia

2. DATE OF DEATH: 11/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1514 Division st

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 23 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 618 Carrollton Ave 16-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | Apr 4 1909 | 40 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Louise Co. Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James C Tinsley
14. MOTHER'S MAIDEN NAME: Maggie Boller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Edmonia Tinsley ADDRESS: 818 N. Carrollton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Carcinoma of Ovaries
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Secondary Anemia

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/29, 1949, *to* 11/3, 1949, *that I last saw the deceased alive on* 11/3, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Marcus W. Moore M.D.
23B. ADDRESS: Provident Hospital
23C. DATE SIGNED: 11/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 11/6/1949
24C. NAME OF CEMETERY OR CREMATORY: Free Union Cemetery
24D. LOCATION (City, town, or county) (State): Louisa Co. Va

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Mrs Hattie R. Williams
ADDRESS: 332

VS 150

49a

correct age is especially important. Typewrite; please write the

G79.573

G79.573

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma C. Dorsey
2. DATE OF DEATH: Nov. 2, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 1717 W. Lexington St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1717 W. Lexington St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1717 W. Lexington St 19-0

5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan. 1, 1891
9. AGE (In years last birthday): 58
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Jones
14. MOTHER'S MAIDEN NAME: Amanda Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Benjamin Cooper ADDRESS: 1736 W Lexington St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Arteriosclerotic and hypertensive Cardiovascular Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1949 to Nov 2, 1949 that I last saw the deceased alive on Nov. 2, 1949 and that death occurred at 11.45 P.M., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 1534 W. Lexington St
23C. DATE SIGNED: Nov 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 5 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Miss Katie R Williams ADDRESS: 332 N Schroeder St

93D

VS 150

D29629 G79574 ✓ G79574 D29629

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

58 P Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Anderton, sr. | 2. DATE OF DEATH 11-4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A STATE Maryland | B COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore — Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 3111 Lawnview Ave. 8-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | | Feb 19 1902 | 47 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY: Mgr. Annheuser Busch | 11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank Anderton | 14. MOTHER'S MAIDEN NAME: Rose Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute coronary thrombosis | 6 hours |
| DUE TO | (B) Massive gastric hemorrhage | 3 days |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) Cirrhosis of liver | 1 year or more |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION: None | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 1, 1949, *to* Nov. 4, 1949, *that I last saw the deceased alive on* Nov. 4, 1949, *and that death occurred at* 9 45 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Clifford T. Riddle Jr. M. D. | 23B. ADDRESS: Mercy Hospital | 23C. DATE SIGNED: 11-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Nov. 7, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer | 24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 5 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR: H. H. Weaks and Son. | ADDRESS: 805 N. Calvert St.

VS 150

124B

G79575

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

401 3 G79575 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA TOYE

2. DATE OF DEATH: 11-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1309 Mosher Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1309 Mosher St. 16-2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | Dec. 25, 1908 | 41 40 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Calvert County, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Wallace
14. MOTHER'S MAIDEN NAME: Mary Stewart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Dessales Toye ADDRESS: 1309 Mosher St., Balt'Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic heart disease.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-5-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov.9, 1949 | Brooks Chapel | Calvert County, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 6 1949
REGISTRAR'S SIGNATURE: [illegible] Williams M.D.
25. FUNERAL DIRECTOR ADDRESS: Charles H. Alexander 1200 McCulloh St.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

951

BIRTH NO. G79576

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 974.0 Registered No. G79576

1. NAME OF DECEASED (Type or Print): GUS SARUS — N-991

2. DATE OF DEATH: November 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-1
D STREET ADDRESS (If rural, give location): 1652 E. Pratt Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Single | Abt. 1891 | 58 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Vendor | ----- | Greece | Unknown |

13. FATHER'S NAME: George Sarus
14. MOTHER'S MAIDEN NAME: Katinka Trousis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 218-01-9965
17. INFORMANT: Mrs. James Lambros 1616 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia
DUE TO
(B) Hanging
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1652 E. Pratt St. 3-01
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Found: Nov. 3, 1949 12m. noon
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by sash cord

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Nov. 3, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | Greek Orthodox Evangelismos | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 6 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR AND ADDRESS: Geo. S. Agnew Funeral Home 118 W. Mt. Royal Ave
Geo. S. Agnew Funeral Home, Inc.
164a

VS 151 NOV 6 1949

G79577 BALTIMORE CITY HEALTH DEPARTMENT G79577

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MILTON V. THOMAS

2. DATE OF DEATH Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3109 Ravenwood avenue
c. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-1
D. STREET ADDRESS (If rural, give location) 3109 Ravenwood avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | white | married | Oct. 12, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired B. & O. | R.R. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME Capt. John Thomas

14. MOTHER'S MAIDEN NAME Sarah C. Egan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO none

17. INFORMANT ADDRESS 3109 Ravenwood ave. Mrs. Minnie M. Thomas

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardio Vascular disease | 8 yrs |
| DUE TO (B) | Coronary Thrombosis. | 1 hour |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 2, 1949, to Nov 3, 1949, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. M. Evans | 1202 St Paul St | 11/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 6 vs 1949 | Registrar for Williams, M.D. | Chas. F. Evans & Son, Inc. 118 N. Mt. Royal Ave |

Chas. F. Evans & Son, Inc.
93d

G79578 G79578

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4300

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kennedy Evans EWING 520004

2. DATE OF DEATH: NOV 5 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Brady 6

C. Length of stay in Baltimore: 1 Da (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Fla.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bartow
D. STREET ADDRESS (If rural, give location): ?

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | 3-3-1892 | 57 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Secty & Treas | Alturas Packing Co. | Uniontown Pa. | |

13. FATHER'S NAME: John K Ewing Sr.

14. MOTHER'S MAIDEN NAME: Mary Mitchell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|---|
| Yes | World War I | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia, staphylococcal — 6 wks

DUE TO

(B) Acute endocarditis — 6 wk

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 11-4-1949 to 11-5-1949, that I last saw the deceased alive on 11-5-1949, and that death occurred at 6:25 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph D. D. King M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov 5 1949 | Wildwood Cemetery | Bartow-Fla. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 8 1949 | Remington for Williams, M.D. | Wm. J. Tickner & Sons North-La Rue |

correct age is especially important. Physicians: please answer questions

9 1 t

CERTIFICATE CORRECTED 11-14-49 ✓

G79579 G79579

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LILLIAN KORTEN

2. DATE OF DEATH Nov. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
218 E. Preston St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-1
D. STREET ADDRESS (If rural, give location) 218 E. Preston St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 12-29-1867~~1868~~ | 81 ~~82~~ | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | New York County, N.Y. | |

13. FATHER'S NAME
Phillip Duffy

14. MOTHER'S MAIDEN NAME
Kathryn Fitzgerald

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | W.B. Woodyard, 218 E. Preston St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral haemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6 - 1, 1944 *to* 11 - 5, 1949 *that I last saw the deceased alive on* 11 - 4, 1949 *and that death occurred at* 2.30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Edmund Levin M.D. | 3400 Hilton Rd | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/ | Woodlawn | New York, N.Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 5 1949 | for Wm. [illegible] | William Cook, Inc., 1217 St. Paul St. |

NOV VS-150 This certificate taken in by mail 8 3a

G79580

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1949 Registered No. G79580

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PEARL W. LONG

2. DATE OF DEATH: 11-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. 1 Mos. 24 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: CARROLL COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CARROLLTON
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | MARRIED | DEC 14 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | | MARYLAND | U.S.A. |

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: NOT KNOWN

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | HUSBAND | CARROLLTON, MD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA, METASTATIC — DUE TO SOURCE UNDETERMINED

(B) — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 9-24-49 | Metastatic CA in liver, larger & small intestine | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/7/1949 *to* 11/6/1949, *that I last saw the deceased alive on* 11/6/1949, *and that death occurred at* 12:20 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank W. Bahen, M.D. | St. Joseph's Hospital | 11/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV. 8. 1949 | CARROLLTON CHURCH OF GOD | CARROLLTON CARROLL COUNTY MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 8 1949 | Registrar for Baltimore, Md. | JOHN R. BYERS WESTMINSTER, MD. |

VS 150

462

G79-81

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4201 G79-81

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alfred Frederick Krug

2. DATE OF DEATH: Nov-5-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 400 Cedarcroft Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 27-12
D. STREET ADDRESS (If rural, give location): 400 Cedarcroft Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June-26-1875 | 74 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY: Auto Supplies

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore F. Krug

14. MOTHER'S MAIDEN NAME: [illegible] Weise
Elise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 216-01-1803A

17. INFORMANT: Mrs. Elsie C. Krug (wife) ADDRESS: Baltimore, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Coronary artery occlusion with Myocardial infarction — 4 years

DUE TO

(C) Coronary arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Emphysema — 8 years

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec., 1943, *to* Nov. 5, 1949, *that I last saw the deceased alive on* Oct 29, 1949, *and that death occurred at* 9:20A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard N. Tillman M. D.

23B. ADDRESS: 3035 St. Paul St

23C. DATE SIGNED: Nov. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov-7-1949.

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Stewart & Mowen Co., 108 W. North Avenue.

VS 150

94a

City #1.

G79582

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79582

1. NAME OF DECEASED (Type or Print): William J Donaldson

2. DATE OF DEATH: 11/2/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Anderson Home.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Nursing Home.

c. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Liberty Heights + Hillsdale
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 1511 Williams St 24-4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | Widower | 3/25/1867 | 82 | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Eng | B & O R R | Maryland | USA |

13. FATHER'S NAME: Geo J. Donaldson

14. MOTHER'S MAIDEN NAME: Cath Duvall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | — | Mrs Helen Hart. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Aortic Aneurism — INTERVAL BETWEEN ONSET AND DEATH: 4 hr.
DUE TO
(B) Hardened Arteries & High Blood Pressure — 2 yrs
DUE TO
(C) none

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Aug 7, 1949 *to* March 1949 *that I last saw the deceased alive on* 11/2, 1949 *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr A E Heath | 2901 Garrison Blvd | 11/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | Loudon Park | Frederick Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 6 1949 | Huntington Williams, M.D. | J. J Lahey Sons | 96 |

VS 150

G79583 ✓ G79583

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 163

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John W. Goodman

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6016 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6016 Eastern Ave. 26-5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | July 31, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Real Estate | Broker | Baltimore | |

13. FATHER'S NAME: George Goodman

14. MOTHER'S MAIDEN NAME: Annie Bassett

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Elizabeth Goodman ADDRESS: 6016 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Carcinoma | 15 mo. |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | none | |
| DUE TO | | |
| (C) | none | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1-5-49 19__, *to* 11-3-49 19__, *that I last saw the deceased alive on* 11/3/49 19__, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| + H Hartmann M. D. | 1710 E 33rd St | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | Oak Lawn | 7225 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 6 1949 | Registrar for Millicent, M.D. | Clarence F. Hoffmann 1639 Broadway. |

NOV 8 150

Correct age is especially important for persons 70 years of age and over

47d

G79584 ✓ G79584

BALTIMORE CITY HEALTH DEPARTMENT 443

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary E. Byrne

2. DATE OF DEATH: Nov. 3-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3114 Northern Pkwy

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-5

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3114 Northern Pkwy

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Feb. 28-1883

9. AGE (In years last birthday): 66 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Katzenberger

14. MOTHER'S MAIDEN NAME: Mary Jane Mc Coy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Dennis J Byrne ADDRESS: 3114 Northern Pkwy

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

(B) Hypertensive Cardiovascular Dis.

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1948, *to* Nov. 3, 1949, *that I last saw the deceased alive on* Nov. 3, 1949, *and that death occurred at* 6.00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles B. MacMunn M. D.

23B. ADDRESS: 2900 E. Balto. St. Balto. 24 Md.

23C. DATE SIGNED: Nov. 4, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-7-49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 6 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Luck ADDRESS: 5305 Harford.

932

VS 150

Dr. Hamburger
1207 Eutaw Pl.

G79585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45.0

G79585
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret F. Louis - Allessi

2. DATE OF DEATH: Nov. 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4803 Pilgrim Rd.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 27-3
D. STREET ADDRESS (If rural, give location): 4803 Pilgrim Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | widowed | Dec 11-1863 | 85 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John

14. MOTHER'S MAIDEN NAME: Ellen Mc Carthy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Rita Louis - ADDRESS: 4803 Pilgrim

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Nephritis (arteriosclerotic) signs & symptoms 4 yrs.

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C) Generalized arteriosclerosis signs and symptoms 8 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 10, 1947, *to* Nov 3, 1949, *that I last saw the deceased alive on* Nov 3, 1949, *and that death occurred at* 12 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis P. Hamburger M. D. | 1207 Eutaw Place | Nov 5 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 11-7-49 | Mt Lathusel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 6 1949 | Huntington Williams M.D. | Leonard Peck | 5305 Harford |

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G79586

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Hro. 1

Registered No. G79586

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary A. Bell

2. DATE OF DEATH: Nov. 4, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3023 Frederick Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3023 Frederick Ave. 20-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Feb. 8, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H. W. | | Maryland | |

13. FATHER'S NAME: Benjamin Lanham

14. MOTHER'S MAIDEN NAME: Maria Grafton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT (Son) ADDRESS: Mr. Edward Bell, 5825 Halwyn Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY OCCLUSION. — INTERVAL BETWEEN ONSET AND DEATH: 17 days

DUE TO

(B) Arterio-sclerosis and senility — 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | 0 | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None. | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 0 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct, 18, 1949, *to* Nov, 4, 1949, *that I last saw the deceased alive on* Oct, 31, 1949 *and that death occurred at* 9 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. Lloyd Johnson M. D.

23B. ADDRESS: 610. Frederick Road Catonsville (Balto-28) Md.

23C. DATE SIGNED:

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 7 49 | New Cathedral | 4300 Old Frederick Rd Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry A. Wintz — ADDRESS: 4101 Edmondson Ave.

94a

VS 150

G79587 ✓x G79587

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59 ✓ Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Lorenz

2. DATE OF DEATH: NOV 6 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE D. C. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington

D. STREET ADDRESS (If rural, give location): 317 - 10th N. W.

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 8-2-11 | 38 | 5 | 4 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm J. Oneal

14. MOTHER'S MAIDEN NAME: Margaret Cagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — JOHNS HOPKINS HOSPITAL — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic glomerulonephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17-1949 *to* 11-6-1949, *that I last saw the deceased alive on* 11-6-1949, *and that death occurred at* 1035 m. *from the causes and on the date stated above.*

23A. SIGNATURE: J. C. Vardell, Jr. M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 11/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 11/7/49

24C. NAME OF CEMETERY OR CREMATORY: Washington D.C.

24D. LOCATION (City, town, or county) (State): Washington D.C.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm J. Trapnell & Sons

26. ADDRESS: 1314

VS 150

Correct Age if especially important. Physicians, please write plainly.

G79588 G79588

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 41

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) CLARA V. O'DONNELL | 2. DATE OF DEATH Nov. 5, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Howard |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Jenkins Conv. Home 1708 Eutaw Place | C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Ilchester |
| c. Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Mar. 22, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stegnopher, retired | | Montgomery Co., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James O'Donnell | Mary E. Ray |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | John F. O'Donnell | Catonsville, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Asthma

DUE TO

(B) Arteria - Sclerotic C.V.D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Osteo - Arthritis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug 13, 1949 *to* Nov 4, 1949 *that I last saw the deceased alive on* 11/4, 1949 *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harold J. Hawkins M. D | 2331 Eutaw Place | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Washington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

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G79589

MS--133202

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49°

G79589 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lawrence Leight

2. DATE OF DEATH 11-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore — Yrs. Life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3035 Reese St.

9-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Wid. | Nov. 19, 1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Carpenter | Building | Maryland | |

13. FATHER'S NAME Lewis W. Leight

14. MOTHER'S MAIDEN NAME Ruth Smuck

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | | Records--Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Lobar pneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-4- , 1949 *to* 11-5- , 1949, *that I last saw the deceased alive on* 11-5- 1949, *and that death occurred at* 7:45 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Cogan M. D. | B.C.H.--4940 Eastern Ave. | 11-5-49 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~OR CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/4/49 | U.S. National | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

108

G79590 ✓ G79590

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. 3 34 Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES J. PETERSON
2. DATE OF DEATH: Nov.5,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 214 N. Culver St.
C. Length of stay in Baltimore: 33 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 214 N. Culver St. 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug.6,1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Rigger | American Sugar Ref.Co | Sweden | |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Matilda (Unknown)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Mrs Emma C. Peterson, 214 N. Culver St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hapleyy
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 24hrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 15 dt, 1949 *to* Nov.5 dt, 1949, *that I last saw the deceased alive on* Nov. 4 dt, 1949 *and that death occurred at* 6:40A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. J. McDermott M. D. | 1136 Poplar Grove St | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 7 1949 | Huntington Williams III | William Cook, Inc., 1217 St.Paul St. |

VS 150

83a

679:91

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679:91

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Butler

2. DATE OF DEATH: 11/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Halethorpe
D. STREET ADDRESS (If rural, give location): Jenie Ave (Rural)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | single | 10/28/1937 | 12 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | Public School | Balto. Md. | |

13. FATHER'S NAME: James M. Butler

14. MOTHER'S MAIDEN NAME: Catherine L. Schroeder

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | James M. Butler | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracerebral hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Thrombocytopenia

DUE TO

(C) Lymphatic leukemia, acute

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/1, 1949 *to* 11/5, 1949 *that I last saw the deceased alive on* 11/5, 1949, *and that death occurred at* 2 5/6 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fred L. McCulloch, M. D. | University Hosp. | 11/5 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~OR CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Meadow Ridge | Dorsey Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS. 150

74a

Correct age is especially important. Typewriter preferred. Typewriter must be used in signing.

G79592

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59

G79592

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES NORMAN FITCH

2. DATE OF DEATH: 11/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6911 Prottsman av.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 12/5/00 | 48 | 10 | 29 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber | Building | Baltimore | U.S. |

13. FATHER'S NAME: James J. Fitch

14. MOTHER'S MAIDEN NAME: Mary Roth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 220-05-5671

17. INFORMANT: Naomi M. Fitch ADDRESS: 6911 Prottsman Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic glomerular nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/4/49, 1949 *to* 11/4, 1949 *that I last saw the deceased alive on* 11/4, 1949, *and that death occurred at* 7:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Kraemer M. D. | Sinai Hospital | 11/4/49 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| 11/7 1949 | Huntington Williams M.D. | Wm Cook Inc. 127 St. Paul St. |

VS 150

131B

679.93 CERTIFICATE CORRECTED 11-21-49 ✓ E 8 21 0 679.93

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. N-213.7

1. NAME OF DECEASED (Type or Print): Elmer Slert (SLERT)

2. DATE OF DEATH: Nov. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1627 Beason St. 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | June 27, 1929 | 20 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tractor operator | Mathieson Co. | Balto. Md. | |

13. FATHER'S NAME: William A. Slert

14. MOTHER'S MAIDEN NAME: Louisa J. Reese

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 217-26-5494 | William A. Slert | 1627 Beason St. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Fracture of skull

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Harbor | Pennington Ave. & Arsen St. 25/5 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 5th 1949 1 P m. | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | Backed tractor off wharf into water |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L. Kruger M.D. | | 6 NOV 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/9/49 | Cedar Hill | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 | Huntington Williams M.D. | Wm. Cook Inc. | 1217 St. Paul St. |

VS 151

170c

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79:94

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

451

Registered No. G79:94

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NOBLE J. CAVENDER

2. DATE OF DEATH Nov. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
522 N. Luzerne Avenue

c. Length of stay in Baltimore 11 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
Baltimore

D. STREET ADDRESS (If rural, give location)
522 N. Luzerne Avenue 7-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Dec. 5, 1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Enginman | Penna. R.R. Co. | Delaware | USA |

13. FATHER'S NAME
William Cavender

14. MOTHER'S MAIDEN NAME
Sadie ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | 716-12-3022 | 522 N. Luzerne Avenue -5 Mrs. Annie M. Cavender |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis (myocardial failure) — INTERVAL BETWEEN ONSET AND DEATH: Sept 3/49
DUE TO arterio-sclerosis -

(B) cirsoid aneurysm of abdominal aorta
DUE TO arterio-sclerosis -

(C) Blood Wassermann - negative

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 16-1948 - Exploratory Laparotomy | aneurysm of abdominal aorta - | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 3 1949, *to* Nov 4 1949, *that I last saw the deceased alive on* Nov 4, 1949, *and that death occurred at* 6:55 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis B. Krumeen M. D. | 722 W. Lenwood Ave | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/8/49 | Bethel Cemetery | Chesapeake City, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 7 1949 | Huntington for Williams, M.E. | HENRY SANDER & SONS, INC. |

VS 150

96

G79595

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 331 Registered No. G79595

1. NAME OF DECEASED (Type or Print): William C. West

2. DATE OF DEATH: 11-4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1632 E 32nd St 9-06

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: Oct 15-1872 | 9. AGE (In years last birthday): 77 | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired policeman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): USA Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Columbus West

14. MOTHER'S MAIDEN NAME: Julia C. Hinkle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: 1632 E. 32nd. ~~Street~~ - 18 Mr. Wm. G. Schuppner

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebus vas. accident — INTERVAL BETWEEN ONSET AND DEATH: 3 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) hypertensive

DUE TO

(C) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4, 1949, *to* 11-4, 1949 *that I last saw the deceased alive on* 11-4, 1949 *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Burton V Lech M.D. M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 11-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 11/8/49

24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND

83a

G79596

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79596

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH HELEN WOLFE

2. DATE OF DEATH: NOVEMBER 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4703 HAMPNETT AVE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PINE RIDGE NURSING HOME.

c. Length of stay in Baltimore: 5 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 421 E. 31ST STREET. 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | WIDOWED. | 9-15-72 | 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE.

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): EMORY, VIRGINIA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: THOMAS J. WARREN

14. MOTHER'S MAIDEN NAME: SARAH MALLICOTE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: MARVIN L. WOLFE. ADDRESS: 4311 MARBLE HALL RD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHO-PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS.

DUE TO

(B) SENILE PSYCHOSIS. — 1 YEAR

DUE TO Generalized Arteriosclerosis

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: NONE.

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NO

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26-, 1949 *to* 11-6-, 1949 *that I last saw the deceased alive on* 11-6-, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur Karlquin, M.D.

23B. ADDRESS: 4230 40CH RAVEN BLVD

23C. DATE SIGNED: 11-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 9 1949

24C. NAME OF CEMETERY OR CREMATORY: Columbia Gardens

24D. LOCATION (City, town, or county) (State): Arlington County Va

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry Sander + Sons Inc

ADDRESS: Baltimore Md

VS 150

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C79597 ✓ C79597

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-16800 — 49 ✓ — Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD ANDERSON

2. DATE OF DEATH: October 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 884 Tyson Street 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | | Aug. 7 1949 | | 2 | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Anderson
14. MOTHER'S MAIDEN NAME: Mabel Lottie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT
ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia with interstitial pneumonitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: October 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): NOV 1 1949
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Temperance Williams, M.D.

VS 151

109 ✓

correct age is especially important. Physicians, please fill out causes of death clearly, accurately and completely.

G79598

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79598

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HERMAN SCHOENBERG
2. DATE OF DEATH: 11-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3403 Forest Park Ave
c. Length of stay in Baltimore: 13 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-38
D. STREET ADDRESS (If rural, give location): 3403 Forest Park Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | | 65 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cutter | Clothing | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Loeb | Betchen |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mathilde Schoenberg | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Occlusion | 40 minutes |
| DUE TO | Coronary sclerosis | 3 years |
| (B) | Hypertension | |
| DUE TO | | |
| (C) | Paget's disease | 7 years? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* January, 1949 *to* Nov 5, 1949 *that I last saw the deceased alive on* Nov. 5, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nicholas Sherwood MD | 11 E. Chase St | 11/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-7-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

94a

G79599

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79599

1. NAME OF DECEASED (Type or Print): Nicholas Caras

2. DATE OF DEATH: 11/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1913 N Patterson Park Ave.

C. Length of stay in Baltimore: 4 6 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-or
D. STREET ADDRESS (If rural, give location): 1913 N Patterson Park Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | W | | Dec 25 1884 | 64 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook. | Lunchroom | Greece | U.S. |

13. FATHER'S NAME: Unknown.

14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.

17. INFORMANT: Sophie Bot ADDRESS: 1913 N Patterson Pk

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Heart failure~~ Myocarditis
DUE TO
(B) arteriosclerosis
DUE TO
(C) Hypostatic
DUE TO
Pneumonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

~~Cirrhosis~~

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. , 1947, to Nov. 6 , 1949, *that I last saw the deceased alive on* Nov 6 , 1949, *and that death occurred at* 7 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas L Shaw M.D.

23B. ADDRESS: 1931 N Kenwood Ave

23C. DATE SIGNED: Nov. 6 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 9th 1949

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park

24D. LOCATION (City, town, or county) (State): Windsor Mill Road.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Leo G Brook ADDRESS: 1705 N Patterson Park

VS 150

D. Maurice Shub - 1431 Kenwell Ave 93d Ave

AB-I32068
79600

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79600

1. NAME OF DECEASED (Type or Print): Bessie Minner

2. DATE OF DEATH: II-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hosptials 4940 Eastern Ave.
C. Length of stay in Baltimore: 30yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5229 Denmore Ave. 2-7-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Widowed | June 22-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Kentucky | |

13. FATHER'S NAME: Allen Harris

14. MOTHER'S MAIDEN NAME: Sarah

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|---|
| | | | Records: Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Oedema

DUE TO

(B) Arteriosclerotic cardio vascular disease with cardiac failure

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9-22- 1949 *to* II-3- 1949, *that I last saw the deceased alive on* II-3- 1949, *and that death occurred at* 10.35 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. L. Ryan M. D. | Baltimore City Hospitals | II-5-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | Mt. Calvary Cem. | A.A. Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 7 1949 | Huntington Williams M.D. | Charles L. Law 802 Madison Ave. |

VS 150

93d

79601

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

79601 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GUY STRICKLEN

2. DATE OF DEATH: 11/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 706 WALKER AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | FEB. 23, 1886 | 63 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LANDSCAPE CONSULTANT
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTO. MD.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM F. STRICKLEN
14. MOTHER'S MAIDEN NAME: MARY WILLIAMS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WORLD WAR I
16. SOCIAL SECURITY NO.
17. INFORMANT: LILLIAN W. STRICKLEN ADDRESS: SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pulmonary hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
DUE TO
(B) Probable Ruptured Aortic Aneurysm ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: John R Davis M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 11/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11-8-1949
24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE
24D. LOCATION (City, town, or county) (State): PIKESVILLE MD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO. ADDRESS: 4905 YORK RD.

VS 151

30d

G79602

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79602

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD C. VOLLERDT

2. DATE OF DEATH: Nov. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2428 E. Monument St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2428 E. Monument St. 7-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct. 14, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Horseshoer, retired | Carney & Quinn | Baltimore, Md. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Ethel E. Vollerdt, ADDRESS: 2428 E. Monument St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary occlusion | 1 hr |
| DUE TO (B) | Arteriosclerosis generalized | |
| DUE TO (C) | Previous Coronary occlusion | 2 yrs - |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 17 to Nov 5, 1949 *that I last saw the deceased alive on* Nov 5, 1949, *and that death occurred at* 5A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry L. Warden M. D. | 2900 Alameda Blvd. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Cedar Hill | Brooklyn, N.Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | Wm. Cook, Inc. | 1217 St. Paul St. |

VS 150

94 a

BIRTH NO. 49-133162

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

Registered No. G79603

1. NAME OF DECEASED (Type or Print): Josephine Przybysz

2. DATE OF DEATH: 11-5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2444 Fleet St. 1-03

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 25-1904

9. AGE (In years last birthday): 45 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Martin Mrozenski (Mrozinski)

14. MOTHER'S MAIDEN NAME: Catherine Koczorowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Glomerulonephritis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-3- , 1949 *to* 11-5 , 1949, *that I last saw the deceased alive on* 11-5- , 1949 *and that death occurred at* 12.15 PM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED: 11-5-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/9/49

24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George A. Weber

ADDRESS: 705 South Ann Street

VS 150

1310

79604

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79604

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM Edward LLoyd

2. DATE OF DEATH: 11-4-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 1313 N. EDEN St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1313 N. EDEN ST. 9-09

5. SEX: M
6. COLOR or RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 10-17-1884
9. AGE (In years last birthday): 65 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PORTER (RETIRED)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, Md
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: SAMUEL M. LLoyd
14. MOTHER'S MAIDEN NAME: MARY TROTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: ISABELLE LLoyd ADDRESS: 1313 N. EDEN, St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular Nephritis and Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos. Indef.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-4-49, 19__, to 11-4-49, 19__, that I last saw the deceased alive on 11-4-49 and that death occurred at ____ m., from the causes and on the date stated above.

23A. SIGNATURE: Jas. R. Blake M. D.
23B. ADDRESS: 1603 N. Carolina
23C. DATE SIGNED: 11-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11-7-49
24C. NAME OF CEMETERY OR CREMATORY: MT. CALVARY
24D. LOCATION (City, town, or county) (State): A. A. County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph S. Locke, Jr. ADDRESS: 1304 N. Central Ave

VS 150

932

679605

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679605

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Benjamin Hopkins

2. DATE OF DEATH 11-5-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 11-04
d. STREET ADDRESS (If rural, give location) 1134 Stoddard Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | Dec. 10, 1894 | 55 54 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Md. | |

13. FATHER'S NAME Jeremiah Hopkins

14. MOTHER'S MAIDEN NAME Fannie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Lizzie Hopkins | 1134 Stoddard St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive - Cardio - Renal Disease | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* [illegible] 19[illegible], to [illegible], 19[illegible], *that I last saw the deceased alive on* [illegible] 19[illegible] *and that death occurred at* [illegible] m. *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | [illegible] Hospital | 11-5-49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 10, 1949 | Mount Auburn | Westport, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1949 | [illegible] | Charles H. Alexander | 1200 McCulloh St. |

VS 150

131a

79606

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44

G79606

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Catherine Langmann

2. DATE OF DEATH: Nov. 5th. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1324 S. Charles St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1324 S. Charles St. Balto. MD.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Baltimore Maryland
D. STREET ADDRESS (If rural, give location)
23-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Sept. 25. 1879 | 70 | 1 | 13 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home duties
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry Schaefer
14. MOTHER'S MAIDEN NAME: Johanna Grecht
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Marguerite Langmann ADDRESS: 1324 S. Chas St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio vascular disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronal & cerebral arteriosclerosis — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 2 yrs. (B) 2 yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 22, 1949 *to* Nov. 5, 1949 *that I last saw the deceased alive on* 11/4/49 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Weibel M. D.
23B. ADDRESS: 1226 Hanover St.
23C. DATE SIGNED: 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 8, 1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore MD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mamie C. Syfer ADDRESS: 1600 W. North Ave.

VS 150

131a

CERTIFICATE CORRECTED 11-7-49 ✓

ES-133179

79607

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Reg. No. 679607

Registered No.

1. NAME OF DECEASED (Type or Print): Jeremiah (Jerry) Holmes

2. DATE OF DEATH: 11-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BALTIMORE CITY HOSPITALS
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 63 W. WEST STREET (30) 2 3 - 0 1

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 25, 1889
9. AGE (In years last birthday): 59 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (D)
14. MOTHER'S MAIDEN NAME: (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): YES
(If yes, give war or dates of service): WORLD WAR I
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Hypertensive arteriosclerotic Heart Disease
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-3, 1949, *to* 11-4, 1949, *that I last saw the deceased alive on* 11-4, 1949, *and that death occurred at* 2:35 A. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED: 11-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 11-8-1949
24C. NAME OF CEMETERY OR CREMATORY: Belts National Cemetery
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Walter B. Springs ADDRESS: 63 W. Lanvale St

VS 150

93d

G79608

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 625 G79608

BIRTH NO. 29-23281

1. NAME OF DECEASED (Type or Print): Paul Jane Znamirowski

2. DATE OF DEATH: November 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 203 S. Ann Street 2-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Fe. | White | Single | Oct. 30/49 | | 7 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore, Maryland | |

13. FATHER'S NAME: Melvin F. Znamirowski

14. MOTHER'S MAIDEN NAME: Jessie Stella Bednarzyk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Atelectasis, Neonatorum

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/29/ , 19 49 *to* 11/5/ , 19 49 *that I last saw the deceased alive on* 11/5/ , 1949 , *and that death occurred at* 10:50 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank W. Baker, M.D. | 1100 N. Caroline Street | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 7-49 | Holy Cross | Baltimore |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Fred W. Gaggert Co 159 930 Eastern Ave

VS 150

G79609

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79609

1. NAME OF DECEASED (Type or Print): LAMBROS PAYIAVLAS

2. DATE OF DEATH: November 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland (Dianes)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Agnes

C. Length of stay in Baltimore: 31 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 639 South Savage Street 26-05

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 1892
9. AGE (In years last birthday): 57 sml (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Assorter
10B. KIND OF BUSINESS OR INDUSTRY: Bethlemen Steel
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Payiavlas
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 213-09-1202

17. INFORMANT: Leo Payiavlas ADDRESS: 639 S. Savage St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 7-49
24C. NAME OF CEMETERY OR CREMATORY: Greek Int. Soc.
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sambras Funeral Home
ADDRESS: 440 E. Fourth Ave.

VS 151

831

G79610

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 983.0

G79610
Registered No.

N-803.7

1. NAME OF DECEASED (Type or Print): Harry Kercherville

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY: Pr Geo
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Laurel
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE, MARRIED~~ ~~WIDOWED~~ DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Divorced | June 3 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Construction | Burtonsville, Md | U.S |

13. FATHER'S NAME: George Kercherville

14. MOTHER'S MAIDEN NAME: Margaret Merson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs Ida Leadman | Laurel Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Compound, comminuted fracture of skull

DUE TO

(B) Sub Dural Hemorrhage

DUE TO

Sub arachnoid Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | Laurel Maryland |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK | NOT WHILE AT WORK | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| Nov. 6, 1949 ab't. 3 A m | | X | Struck on head with shovel |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER X ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Nov. 7, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 9 1949 | Try Hill | Laurel Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | Wm H Hendrickson | Laurel Md |

VS 151

168

C79611

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C79611

1. NAME OF DECEASED (Type or Print): STERLING E. DORSEY

2. DATE OF DEATH: Nov. 5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION: 1411 Druid Hill (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 14-ex
D. STREET ADDRESS (If rural, give location): 1411 Druid Hill Ave

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Jan. 21-1896
9. AGE (In years last birthday): 53 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Hauler
11. BIRTHPLACE (State or foreign country): Carrol County, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Theodore Dorsey
14. MOTHER'S MAIDEN NAME: Maggie Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WORLD WAR I
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Theodore Jones ADDRESS: 1411 Druid Hill Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Renal Disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Peptic Ulcer

INTERVAL BETWEEN ONSET AND DEATH: (A) 7 (C) 9

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct-1-1949 to Nov 5, 1949, that I last saw the deceased alive on Nov 5-1949 and that death occurred at 10 P m., from the causes and on the date stated above.

23A. SIGNATURE: S. B. Hughes M. D.
23B. ADDRESS: 1413 Druid Hill Ave
23C. DATE SIGNED: Nov-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 9-'49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cem.
24D. LOCATION (City, town, or county) (State): New Windsor R. D. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Emerson Williams, M.D.
25. FUNERAL DIRECTOR: H. O. Hartzler & Sons ADDRESS: 1310 Clinton Bridge & New Windsor, Md.

VS 150

679612

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679612

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE HUGO GOLDSCHMIDT

2. DATE OF DEATH: Nov. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hosp. 2724 N. Charles St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2307 Robb St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) |
|---|---|---|
| male | white | married |

| 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|
| Sept. 29, 1882 | 67 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Soap Manufacture
11. BIRTHPLACE (State or foreign country): Balto., Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George H. Goldschmidt
14. MOTHER'S MAIDEN NAME: Rosalie Kerndl
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 212-07-1088
17. INFORMANT: Mrs. Wilhelmina C. Goldschmidt ADDRESS: 2307 Robb St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 7 |
| DUE TO (B) | Arteriosclerosis | 2 |
| DUE TO | Cardiac Insufficiency | - |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6/24, 19[illegible] *to* 11/4, 1949 *that I last saw the deceased alive on* 11/31, 1949 *and that death occurred at* 2[illegible]0 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel L Grum M.D.
23B. ADDRESS: 1201 E. North Ave.
23C. DATE SIGNED: 11/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/7/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

94a

79613

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 no. 1

G79613

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MINNIE MANLY

2. DATE OF DEATH Nov. 5 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3307 Egerton Rd.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 3307 Egerton Rd. 1-5-11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | May 1, 1874 | 75 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York City, N. Y.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME William Young
14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | no |

17. INFORMANT Mrs. Frances M. Dasch ADDRESS 3401 Copley Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — (INTERVAL BETWEEN ONSET AND DEATH) 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis & hypertension — 8 yrs

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 10, 1949, *to* Nov. 5, 1949, *that I last saw the deceased alive on* Nov. 4, 1949, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin D. Siegel M. D. | 15 Greenwood Rd. Pikesville Md. | Nov. 5 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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G79614 ✓ G79614

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 16 ✓ Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Basile

2. DATE OF DEATH: 11/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. 27 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4110 Kinsway 34

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | June 28 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| barber | barber | Italy | U.S.A. |

13. FATHER'S NAME: Marco Basile

14. MOTHER'S MAIDEN NAME: Marguerita Basile

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes World War II | — | Hospital Records, Mercy Hosp. Calvert & Lanvale |

## MEDICAL CERTIFICATION

CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia. | 7 days |
| | DUE TO (B) Pulmonary edema. | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Carcinoma of Rt. Lung | 10 months |
| | (C) & metastases to mediastinum and brain. | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Dec. 1948 | Pneumonectomy rt. (Carcinoma of Rt. Lung) | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 27, Oct., 1949, *to* 5, Nov., 1949, *that I last saw the deceased alive on* 5, Nov., 1949, *and that death occurred at* 10:55 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | Mercy Hosp. 4110 Kinsway Balto. | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 9 1949 | Holy Redeemer Cem. | Belair Rd Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | [illegible] | [illegible] | [illegible] |

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AB-133231

79615
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 79615

1. NAME OF DECEASED (Type or Print): Jennie Sloffer

2. DATE OF DEATH: 11-5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave,
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 876 W. Lombard St. 1803

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | May 6- 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | - | Maryland | |

13. FATHER'S NAME: August Stillmeyer
14. MOTHER'S MAIDEN NAME: Alice Mistelhorn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | None | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable coronary thrombosis
DUE TO
(B) Saddle embolus
DUE TO
(C) Arteriosclerotic cardio vascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
For C. J. Lubinski, M.D.
W. J. McClafferty M.D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-5- , 1949, *to* 11-5- , 1949 *that I last saw the deceased alive on* 11-5- , 1949, *and that death occurred at* 10.45P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | Baltimore City Hospitals | 11-7-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 8-1949 | Westminster Cem. | Westminster, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | H. Bankard Son Westminster, Md. |

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To be approved by the Medical Examiner 93d

G79616 ✓ G79616

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

45 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George H. Rabll

2. DATE OF DEATH: 4- Nov. 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hospital.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital, Balto. 2, Md.

c. Length of stay in Baltimore: Yrs. Life time Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 6000 York Rd.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md. 27-12
D. STREET ADDRESS (If rural, give location): 6000 york Rd. Balto. md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | 2- April 1869 | 81 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Garden & farming | farm | Harford County | U.S.A. |

13. FATHER'S NAME: George Rabll

14. MOTHER'S MAIDEN NAME: Mary Kelly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO:

17. INFORMANT: John H. Rabll (Son) ADDRESS: Balto. Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive Gangrene lower extremities — INTERVAL BETWEEN ONSET AND DEATH: 10-20-49

DUE TO

(B) Thrombosis of femoral arteries — 4- mos 4d

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10 - 22 , 19 49 *to* 11 - 4 , 19 49 *that I last saw the deceased alive on* 11-3 , 19 49, *and that death occurred at* 11 30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. A. Hillenger, M. D. | Mercy Hospital Balto. Md. | 4-Nov 49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-8-49 | St. Mary's Bovard | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Thurlington Williams, M.D. | J. Walter Conklin | 2343 Harford Rd |

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G79617 CERTIFICATE CORRECTED 11/7/49 G79617

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

193 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Karl A. Pihlstrom) PIHLSTROM

2. DATE OF DEATH: 11/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 626 Parkwyth Ave 9-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | March 17, 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist | Bethlehem Steel | Norway | |

13. FATHER'S NAME: (Unknown) Pihlstrom

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | John Rasmussen | 626 Parkwyth Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis DUE TO
(B) DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: unknown

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov 2 1949 | Coronary thrombosis | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 28, 1949, to Nov 4, 1949, *that I last saw the deceased alive on* Nov 4, 1949, *and that death occurred at* 9:35 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Franklin Sq Hosp | 11-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Parkwood | Parkville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

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G79618

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

'50 G79618 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Girl CHATARD "B" | 2. DATE OF DEATH: Nov. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Md.
C. Length of stay in Baltimore: One Hrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 27-14
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 10
D. STREET ADDRESS (If rural, give location): 4814 Keswick Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Nov. 5, 1949 | | | 2 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ferdinand Elmo Chatard | Constance Bentley Lyon |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | None | Constance Chatard | 4814 Keswick Rd. Baltimore-10 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anencephaly — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 5, 1949 *to* Nov. 5, 1949 *that I last saw the deceased alive on* Nov. 5, 1949 *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Spencer, M. D. | Hosp. for the Women of Md. | 11-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/7/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | H. O. Means and Son | 5 N. Calvert St. |

NOV 7 1949

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G79619

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79619

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE ROBERTS
2. DATE OF DEATH: 11/5/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen. Hosp.
C. Length of stay in Baltimore: 2 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4411 Reisperstown Rd #6.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | married | July 16, 1857 | 92 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Henry Buel
14. MOTHER'S MAIDEN NAME: Elizabeth Baegety
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Failure
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C) Fracture of Left Hip

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 9/19/49

CERTIFICATION APPROVED BY
For: C. J. Lubinski, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 26-1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 / 19 / 1949 3 p.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur? Fell down stairs at home

22. *I hereby certify that I attended the deceased from* 9/19, 1949 *to* 11/5, 1949, *that I last saw the deceased alive on* 11/5, 1949, *and that death occurred at* 3 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. L. Cressman M. D.
23B. ADDRESS: Maryland Gen. Hosp.
23C. DATE SIGNED: 11/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: 11/8/49
24C. NAME OF CEMETERY OR CREMATORY: LOUDON PARK
24D. LOCATION (City, Town, or county) (State): FREDERICK ROAD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.
25. FUNERAL DIRECTOR: JOHN F. DENNY, INC
ADDRESS: 715 LIGHT ST

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186a

G79620

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79620

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE KOSTIN

2. DATE OF DEATH Nov 5th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1402 Hanbert St 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | MAY 5, 1878 | 71 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY Railroad Bro.

11. BIRTHPLACE (State or foreign country) Romania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Patrician Kostin ADDRESS 1402 Hanbert

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) MILIARY TUBERCULOSIS
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [✓] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV. 5, 1949 *to* NOV. 5, 1949 *that I last saw the deceased alive on* NOV 5, 1949 *and that death occurred at* 1:15p m., *from the causes and on the date stated above.*

23A. SIGNATURE David Auld M. D.

23B. ADDRESS University Hosp.

23C. DATE SIGNED Nov. 5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL.

24B. DATE 11/9/49

24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS

24D. LOCATION (City, town, or county) (State) RITCHIE HIGHWAY

DATE RECEIVED BY LOCAL REGISTRAR NOV 7 1949

REGISTRAR'S SIGNATURE Lavington Williams M.D.

25 FUNERAL DIRECTOR JOHN F. DENNY, INC. ADDRESS 715 LIGHT ST.

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G79621 ✓ X 56.0 G79621

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lucy Blanche Skipper
2. DATE OF DEATH: 11/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania MARYLAND - B. COUNTY: Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Timonium -
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Dec 1, 1871 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Maryland - | USA |

13. FATHER'S NAME: Joshua Staler
14. MOTHER'S MAIDEN NAME: Deborrah Cornell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | None | George N. Skipper | Same - |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio - vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hr.
DUE TO
(B) Incarcerated hernia -
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/4 *, 19*49*, to* 11/5 *, 19*49*, that I last saw the deceased alive on* 11/5 *, 19*49*, and that death occurred at* 2.45 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. E. Hunt M. D. | Maryland General Hosp. | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Nov. 8, 1949 | Meadow Branch Cemetery | Westminster, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Tuntington Williams, M.D. | John Burns' Sons, | Towson, Md. |

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G79622

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79622
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Regis Eugene Cappelli
2. DATE OF DEATH: 11/6/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: 13 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 804 Linden Ave 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1/8/05 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Barber | Barber Shop | Italy | USA |

13. FATHER'S NAME: Fabrizio Cappelli
14. MOTHER'S MAIDEN NAME: Angelina Gordon Gorgini

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown): No
16. SOCIAL SECURITY NO.: 192-07-8881
INFORMANT: Eugene M. Cappelli
ADDRESS: 1178 Burgundy

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pye Iphlebitis | 4 days |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Post operative Portal Thrombosis, Post operative splenectomy | 5 days |
| DUE TO (C) | Portal Anemia, spleen at Sinai Hospital | 6 months |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/17, 1949, *to* 11/6, 1949, *that I last saw the deceased alive on* 11/6, 1949, *and that death occurred at* 7:30 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Richard Finan M. D. | Mercy Hosp | 11/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 10, 1949 | Calvary Cem. | Pittsburgh Penna |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Scott & B. M. Walter
ADDRESS: Scott Street

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G79623

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

541.1

Registered No. 158049

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH. Mc CORMICK

2. DATE OF DEATH: 11-5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. Agnes Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-13
D. STREET ADDRESS (If rural, give location): ST. MARY'S SEMINARY

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: St. Mary's Sem.

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN. Mc CORMICK
14. MOTHER'S MAIDEN NAME: ELIBETH. Mc DONALD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: —
17. INFORMANT: MRS KATHERINE Mc CORMICK
ADDRESS: 3729 GUILFORD AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Post gastric. ulcer perforated
DUE TO
(C) Cardiac failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 11/1/49
19B. MAJOR FINDINGS OF OPERATION: Perforated Duodenal Ulcer
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/1/49, 19__, *to* 11/5, 1949, *that I last saw the deceased alive on* 11/5, 1949, *and that death occurred at* 5:50 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Frank P Dunge M. D.
23B. ADDRESS: St Agnes Hosp
23C. DATE SIGNED: 11/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-8-49
24C. NAME OF CEMETERY OR CREMATORY: St. Johns Cem
24D. LOCATION (City, town, or county) (State): Long Green, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT AVE & 22ND

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G79624

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79624 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ERNEST OHLE

2. DATE OF DEATH: 11-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 728 East North Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 728 East North Avenue 9-8

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 1886 | 63 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard | Post Office | Baltimore | |

13. FATHER'S NAME: Louis Ohle

14. MOTHER'S MAIDEN NAME: Catherine Mohr

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| yes | W.W.#1 | |

17. INFORMANT: Mrs. Ernest Ohle ADDRESS: 728 E. North Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 14 days

DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-21, 1949, *to* 11-4, 1949, *that I last saw the deceased alive on* 11-4, 1949, *and that death occurred at* 6:55 *p.* m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. H. Logan M. D. | 11 E. Chase St | 11/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-7-49 | Loudon Park | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Lexington Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

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940

BIRTH NO. G79625

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G79625

1. NAME OF DECEASED (Type or Print): Mary Nutter

2. DATE OF DEATH: 11/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1323 Page Court

C. Length of stay in Baltimore: 3 Mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 1323 Page Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W. | 5-31-1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home. | W. Va. | |

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No. | | Family - Same. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) H.A.C.V disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| C. L. Sulzbacher M.D. | | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 11-9-49 | Sinai Memorial | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Washington, Md. | James L. McCauley | 1303 Fort Ave. |

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 241 Registered No.

1. NAME OF DECEASED (Type or Print): FRANK A. LINK
2. DATE OF DEATH: 11/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 105 N. Kenwood Ave
C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-01
D. STREET ADDRESS (If rural, give location): 105 N. Kenwood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 10/27/1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baker | Koester's Bakery | Baltimore Md. | U S A |

13. FATHER'S NAME: Ludwig Link
14. MOTHER'S MAIDEN NAME: Anna Barringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT: Mrs. Anna M. Link ADDRESS 105 N. Kenwood Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Bronchial Asthma — 10 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bilateral Inguinal Hernia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection of Injury *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR X | 23C. DATE SIGNED |
|---|---|---|
| John R Davis M.D. | | 11/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/9/49 | New Cathedral | 4300 Old Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 | Huntington Williams, M.D. | John J. Lowenstein | 2200 Gilmor St. |

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# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

170 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stella Starr-Estella M. Starr | 2. DATE OF DEATH: Nov. 5-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ardleigh Nursing Home

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27

D. STREET ADDRESS (If rural, give location): 3106 Loyola Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Oct. 28-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Stafford Co. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| David Boyd | Lydia |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Milton E. Starr | 3106 Loyola |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Left Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 7-4-49 | Carcinoma Left Breast | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1-20-, 1949 *to* 11-5, 1949, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. W. Peake M. D. | 4508 Harford Road | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-8-49 | Parkwood | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 1949 VS-150 | Huntington Williams, M.D. | Leonard J. Luck-5305 | Stafford |

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Dr Fisher G79628
1823 N. Washington

G79628

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 45-0

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John Ament

2. DATE OF DEATH Nov. 5-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1134 E. 20th St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-ward
D. STREET ADDRESS (If rural, give location) 1134 E. 20th St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | widowed | Apr. 6-1860 | 89 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Retired P.R.R.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Albert Ament
14. MOTHER'S MAIDEN NAME Margaret.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO 214-20-9424
17. INFORMANT M. G. A. Ament ADDRESS 2020 N. Washington

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST,
(B) Arteriosclerosis — 5 yrs.
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 4, 1949 *to* Nov. 5, 1949, *that I last saw the deceased alive on* Nov. 5, 1949, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Carroll Fisher M. D.
23B. ADDRESS 1828 N. Front St.
23C. DATE SIGNED 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11/8/49
24C. NAME OF CEMETERY OR CREMATORY Western
24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR NOV 7 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Leonard J. Luck - 5305 ADDRESS Harford.

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 490 Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH FRANK BEYER
2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2516 Pennsylvania Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2516 Pennsylvania Ave. 15-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Oct. 15, 1890 | 59 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter
10B. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Michael Beyer
14. MOTHER'S MAIDEN NAME: Augusta Anna Pranke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War #1
16. SOCIAL SECURITY NO: 215-05-2647
17. INFORMANT: Mrs. Viola K. McElvaney
ADDRESS: 8514 Chestnut/Towson Oak Av

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Cardiac Dilitation | 11/3/49 |
| DUE TO (B) | Chr. Myocarditis | 1948 |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Labor Pneumonia | 10/26/49 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct- 6, 1949 *to* Nov 6, 1949 *that I last saw the deceased alive on* Nov 5, 1949, *and that death occurred at* 10 15 a *m., from the causes and on the date stated above.*

23A. SIGNATURE: Paul Brown M.D.
23B. ADDRESS: 1663 W. North Av.
23C. DATE SIGNED: 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/9/49
24C. NAME OF CEMETERY OR CREMATORY: Western Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 7 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1220 1

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | BENEDICT HUPFER |
| 2. DATE OF DEATH | Nov. 5, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2123 Lyndhurst Ave. |
| C. Length of stay in Baltimore | 30 yrs. (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Balto. |
| D STREET ADDRESS (If rural, give location) | 2123 Lyndhurst Ave. 1509 |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widow |
| 8. DATE OF BIRTH | Aug. 27, 1860 |
| 9 AGE (In years last birthday) (If under 1 year: Months, Days; If under 24 hours: Hours, Min.) | 89 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Clothing Cutter |
| 10B. KIND OF BUSINESS OR INDUSTRY | Clothing |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12 CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | - Hupfer |
| 14 MOTHER'S MAIDEN NAME | Unknown |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO | none |
| 17 INFORMANT | Mr. Bernard J. Hupfer - |
| ADDRESS | 2123 Lyndhurst Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 12 days |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Physiological Senility | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Oct. 24, 1949, to Nov. 5, 1949, *that I last saw the deceased alive on* 11-5-1949, *and that death occurred at* 12:25 P.m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Maurice E. Hamer M. D. | |
| 23B. ADDRESS | 3300 W. Forth Ave | |
| 23C. DATE SIGNED | 11-7-49 | |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) | |
| Burial | 11/8/49 | Holy Redeemer Cem. | Balto., Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS | |
| | | Wm. J. TICKNER & SONS | Balto., Md. | |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

754.4 Registered No.

BIRTH NO. 49-00677

1. NAME OF DECEASED (Type or Print) (Wilbur Earl Bailey Jr.) Wilber Bailey A69690

2. DATE OF DEATH NOV 6- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 1436 Holbrook, St. 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Single | Jan.1st.,1949 | | 10 / 3 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Md (Balto:Md. | U.S.A. |

13. FATHER'S NAME Wilbur Earl Bailey Wilber Bailey

14. MOTHER'S MAIDEN NAME Florence Rohe ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | None | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Failure
DUE TO
(B) Congenital [illegible]
DUE TO
(C) none

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 day

CORRECTION APPROVED BY
For C.J.Lubinski, M.D.
by B.S.Fisher M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James L Gamble M. D. | JOHNS HOPKINS HOSPITAL | II-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II-9-49 | Holy Redeemer Cemetery | Belair Road, Balto:Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | George J.Ruth, Inc.-1735 Harford Avenue |

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Hospital Disposal

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

776

Registered No. G796332

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Girl Howard

2. DATE OF DEATH: OCT 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days: 4

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Odenton
D. STREET ADDRESS (If rural, give location)

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH: 10-24-49
9. AGE (In years last birthday): If Under 1 Year: Months / Days: 4 / If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Paul Wilson
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24 1949, to 10-28, 1949, *that I last saw the deceased alive on* 10-28, 1949, *and that death occurred at* 6:40 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Lionel Rheuttin M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Hospital Disposal
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

159

G79633

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

776

G79633

BIRTH NO. 49-23074

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Pate

2. DATE OF DEATH: September 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital (Accident Room)

C. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 317 Lafayette Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | 9-14-49 | | | 45 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Izola Wright

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Hospital Records | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Immaturity
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 14, 19 49 *to* Sept. 14, 19 49 *that I last saw the deceased alive on* Sept. 14, 19 49 *and that death occurred at* 8:05A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Andrews M. D. | The Johns Hopkins Hospital | 10-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | | |

VS 150

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G79634 BALTIMORE CITY HEALTH DEPARTMENT 340.1 G79634

BIRTH NO. 19-26848 CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) Albert Powell

2. DATE OF DEATH Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General HOspital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3334 Fairfield Ave. 3334 25-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | March 27 1949 | 7 | 10 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or Foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Baltimore City | U.S.A |

13. FATHER'S NAME Fred E. Powell

14. MOTHER'S MAIDEN NAME ~~Baltimore City~~ Hattie Jones

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Fred E. Powell | 3334 Fairfield Rd |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Meningitis due to pneumoncoccus | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS (IF ANY) GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING I | Atopic dermititis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|---|
| R S Fisher | | | Nov. 7, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 9 1949 | Mt Calvary Cemetery | A.A. Co., Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Robert H. Williams | 1515 Mt Clavary St |

VS 151

81a

G79635

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-22783 — Registered No. G79635

1. NAME OF DECEASED (Type or Print): BABY DEMPSEY
2. DATE OF DEATH: October 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 921 S. Sharp Street 23-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | Colored | | Oct. 15, 1949 | | | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Md. | |

13. FATHER'S NAME: undetermined
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis of lungs, due to

DUE TO

(B) massive hemorrhage into both chest cavities,

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 10-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL NOV 1 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Commissioner of Health

VS 151

161a

G79636

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 49-17842

# CERTIFICATE OF DEATH

Registered No. G79636

1. NAME OF DECEASED (Type or Print): GERALD TYLER

2. DATE OF DEATH: 8 p.m. October 3, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 426 N. Gilmor St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 501 N. Mount Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | | Sept. 2, 1949 | | 1 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Icterus neonatorum
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X] accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L Moyer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 10-4-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. Commissioner of Health | |

UNIVERSITY MEDICAL SCHOOL NOV 1 1949

VS 151

161C

G796537

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-23030 776 Registered No. G796537

1. NAME OF DECEASED (Type or Print): BABY JACKSON

2. DATE OF DEATH: October 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital--Harriet Lane
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1808 E. Eager Street 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | | Oct. 23, 1949 | | | 35 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Md. | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| H. J. McCafferty M.D. | | Oct. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | NOV 1 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

159

B-79638

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. B-79638

1. NAME OF DECEASED (Type or Print)

2. DATE OF DEATH

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| | | | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) .....
DUE TO
(B) .....
DUE TO
(C) .....

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE? (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__ *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | | |

VS 150

B79639

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

B79639

BIRTH NO. | Registered No.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | DAVID | WELLS | 2. DATE OF DEATH: October 19, 1949 |

**3. PLACE OF DEATH:**
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Yrs. / Mos. / Days

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 216 N. Colvin Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| | |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Obliterative coronary sclerosis | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Carl L Rogers M.D. | | 10-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | NOV 1 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

94a

G79640

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20 1

G79640

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Onukiavage

2. DATE OF DEATH: Oct. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): City Jail Dispensary
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 606 E. Baltimore St. 4-21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | | | 37 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obliterative Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. B. Fisher M.D. | | Oct. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 1 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 3 1949 | Huntington Williams, M.D. | Commissioner of Health |

VS 151

949

79641

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G79641

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Julius Parker

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1130 N. StocktonSt.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1130 N. Stockton St. 16-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widower | Nov. 14,1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Maryland | U. S. A |

13. FATHER'S NAME: Plater Parker

14. MOTHER'S MAIDEN NAME: Carrie Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Christian Stevenson | 1130 N. Stockton |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 2 days |
| DUE TO (B) | Hypertensive Cardiovascular Disease | 1 yr |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 3-15, 1949 *to* 11-6, 1949 *that I last saw the deceased alive on* 11-6, 1949 *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Franklin Chalkley M. D. | 1543 N. Stockton St. | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-9-49 | Mt. Auburn Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams M.D. | Mrs Frances A. Hemsley | 578 W. Biddle St |

VS 150

93D

G79642

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79642

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD HUNT

2. DATE OF DEATH: 11/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 17 16-03
D. STREET ADDRESS (If rural, give location): 875 N. Fulton Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | Jan. 11 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Bethlehem Steel Co. | Va. | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Emanuel Hunt. - | Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain Abscess

DUE TO

(B) Meningitis

DUE TO

(C) Aspiration Pneumonia

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/1 19 49 *to* 11/4 19 49 *that I last saw the deceased alive on* 11/4 19 49 *and that death occurred at* 7 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nicholas M. D'Alesandro M. D. | Univ. Hosp. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 8/49 | Arbutus Mem Park | Arbutus Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Mrs Robert A. Elliott & Daughter | 1129 N. Carlin St. 107 |

VS 150

G79643 ✓ 44 G79643

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Adella Booker

2. DATE OF DEATH: II/5/I949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I3I7 Madison Avenue

Dan-Wil-Ba convalescent Home

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City

D. STREET ADDRESS (If rural, give location): I526 East Preston Atreet 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col. | Widow | 2/5/I879 | 71 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Hopkins Hospital | Baltimore City | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Emory Jackson | Annie Sampson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Lillian Bias I526 Preston Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebrovascular Renal | |
| DUE TO (B) | Disease" Hypertension | 1 year |
| DUE TO (C) | | |

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | - | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 5/x 19 49 *to* 11/5 19 49 *that I last saw the deceased alive on* 11/5 19 49 *and that death occurred at* 5a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Jackson M. D. | 600 Darling Road | 11/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II/8/I949 | Arbutus Mem. Park | Arbutus Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Elroy O. Wilson I000 Brantly Ave. |

VS 150

131a

✓ X

579644

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54.5

G79644

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hugh Donald Orr

2. DATE OF DEATH: November 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSP

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Washington
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tacoma
D. STREET ADDRESS (If rural, give location): 1801 E. 35th St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Sold | 11-26-33 | 15 16 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | N. D. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Hugh Orr | Bernice Hansen |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSP |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Hemorrhage, left thorax | 1 min. |
| DUE TO (B) | Thorecotomy for coarctation of the aorta | 2 wks. |
| DUE TO (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/25/49 | Coarctation of the aorta | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-24, 1949 *to* 11-7, 1949 *that I last saw the deceased alive on* 11-7, 1949, *and that death occurred at* 4:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Donald F. Griffith, Jr. M. D. | JOHNS HOPKINS HOSP | 11/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | | Tacoma Wash |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Charles P. Towell | 2427 E. Monument Circle |

VS 150

157F

G79645 CERTIFICATE CORRECTED 11-Vital 9

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 G79645

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT B. HANFT

2. DATE OF DEATH: NOV. 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1246 CARROLL ST.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1246 CARROLL ST 21-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | NOV 8 1885 | 53 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SERVICE MAN | CANTEEN CORP. | MARYLAND | |

13. FATHER'S NAME: GEORGE HANFT

14. MOTHER'S MAIDEN NAME: SUSAN

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | W.W.I | 214-22-1242 | WIFE | MRS ANNA HANFT - 1246 CARROLL ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardio-vascular disease — ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 5 3:00 AM 1949, *to* Nov 5 9:00 AM 1949 *that I last saw the deceased alive on* Nov 5, 1949, *and that death occurred at* 9:00 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ellsworth Cole M. D. | 2431 MARYLAND AVENUE | 11/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV. 8 1949 | LOUDON PARK | BALTIMORE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Harry A Wolfe | 410 EDMONDSON AVE |

VS 150

93D

G79646 ✓ G79646

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 31

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Augusta Ernestine Henkel

2. DATE OF DEATH: 7 November 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Nursing Home 212 Stoney Run Lane

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2922 Hamilton Ave. 27-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Oct. 17, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | | Baltimore, Md. | |

13. FATHER'S NAME: Henry Rau

14. MOTHER'S MAIDEN NAME: Mary Himmler

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | J. Norman Henkel | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 4 days |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Cerebral hemorrhage c Left hemiplegia HEMIPLEGIA | 15 months. A |
| DUE TO | | |
| (C) | Hypertension | unknown. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 15 July, 1949 *to* 6 Nov, 1949, *that I last saw the deceased alive on* 6 Nov, 1949 *and that death occurred at* 4:20A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Blome M.D. | 5202 Harford Rd | 7 Nov 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 10/49 | London Park, 3801 Frederick Rd. | Baltimore, 29, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Harry A. Leitz | 4101 Edmondson Ave |

VS 150

83a

G79647

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

490

G79647

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Jean Peltz (Ella Mae Peltz) | 2. DATE OF DEATH: Nov. 6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2795 Wilkens Ave.

C. Length of stay in Baltimore: 8 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2795 Wilkens Ave. 20-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | Married | April 19, 1917 | 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Virginia | |

13. FATHER'S NAME: H. B. Whitaker

14. MOTHER'S MAIDEN NAME: Elizabeth Menly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Milton Peltz | 2795 Wilkens Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil Kayser M.D. | | 8 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov. 9/49 | | Norton, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Harry A. Nitsch | 4101 Edmondson Ave |

VS 151

108

G79648

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 16 Registered No. G79648

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clara C. Ringsdorf

2. DATE OF DEATH: Nov. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1205 N. Ellwood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1205 N. Ellwood Ave. 8-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | April 6, 1888 | 61 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph W. Tillen, Sr.

14. MOTHER'S MAIDEN NAME: Sarah High

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: John W? Ringsdorf ADDRESS: 1205 N. Ellwood Ave,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute pulmonary oedema — INTERVAL BETWEEN ONSET AND DEATH: 1 hrs.

DUE TO

(B) acute myocardial insufficiency — 4 mo.

DUE TO

(C) rheumatic carditis. — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 28 1949, to Nov. 5, 1949, *that I last saw the deceased alive on* Nov. 5 1949, *and that death occurred at* 9:25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE L. C. Schiled M. D.

23B. ADDRESS 447 N. Kenwood Ave.

23C. DATE SIGNED 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 9, 1949

24C. NAME OF CEMETERY OR CREMATORY: Woodlawn

24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Ullrich Funeral Home 2008 Orleans St.,

VS 150

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9649

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G79649

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (Mrs) Frances MAHER ~~Mayer~~ | 2. DATE OF DEATH: 11 - 5 - 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland | B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 4305 York Road 27-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | married | June 4 / 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Maryland | |

13. FATHER'S NAME: Joseph W. Tellon Sr.

14. MOTHER'S MAIDEN NAME: Sarah Hight

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Silvia P. Maher | 4305 York Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral (Subarachnoid) Hemorrhage | 4 hrs |
| DUE TO (B) | Hypertensive cardio vascular | over 4 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | disease | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hemiplegia terminal pulmonary edema | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11 - 5 19 49 *to* 11 - 5 19 49 *that I last saw the deceased alive on* 11 - 5, 19 49, *and that death occurred at* 8 30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Cadle M. D. | Maryland General Hosp | 11 - 5 - 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/9/49 | Baltimore National | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Remington for Williams, M.D. | Ulrich Funeral Home | 2007 Eutaw St |

VS 150

Medical examiner notified after admission and death of pt 3 hrs 45 minutes release of body. 93 D

G79650

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79650

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Mary Catherine Naylor

2. DATE OF DEATH: November 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2938 Huntingdon Avenue

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2938 Huntingdon Avenue 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | March 10, 1870 | 79 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William Ball

14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: ---

17. INFORMANT: Mrs. Harry R. Stauffer ADDRESS: 1334 W. 41st St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio-renal-vascular Disease — 6 yrs.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 19 1943, *to* Nov. 7, 1949 *that I last saw the deceased alive on* Nov. 7, 1949, *and that death occurred at* 8 15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J N Wilson M. D.

23B. ADDRESS: 617 W. 40th St.

23C. DATE SIGNED: 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 10, 1949

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

131a

G796.51 ✓ G796.51

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Elijah Millard Wheat

2. DATE OF DEATH: November 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2715 Miles Avenue

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2715 Miles Avenue 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 18, 1876 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Electrician | B & O RR Retired | Maryland | U S A |

13. FATHER'S NAME: Zachariah Wheat

14. MOTHER'S MAIDEN NAME: Margaret Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 705-10-2437

17. INFORMANT: Mrs. Mary O. Wheat ADDRESS: 2715 Miles Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ½ hr.
DUE TO
(B) Intermediate C V D.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 2-10, 1976, *to* 11-5, 1979, *that I last saw the deceased alive on* 11-5, 1979, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas E Thomas M. D. | 3711 Falls Rd | 11-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 8, 1949 | Druid Ridge | Pikesville, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Burgee Funeral Home | 3631 Falls Road |

VS 150

93D

G79b52

G79b52

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 470

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH SAUL AUSTER

2. DATE OF DEATH: 11-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 5026 Palmer Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paper Hanger
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ephraim
14. MOTHER'S MAIDEN NAME: Esther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Ella Auster ADDRESS: 5026 Palmer

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | acute Pulmonary edema | 2 hours |
| DUE TO (B) | Recurrent Coronary occlusions | 1½ years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/21/49 *to* December 7, 1949, *that I last saw the deceased alive on* 11/7/, 1949, *and that death occurred at* 5:25 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Joseph L. Myerowitz, M.D.
23B. ADDRESS: 5145 Park Heights Ave
23C. DATE SIGNED: 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-8-49
24C. NAME OF CEMETERY OR CREMATORY: Dror Israel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levos Inc
ADDRESS: 2100 Eutaw Pl

VS 150

94a

79653

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

99-8 G79653 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SIMON HERMAN

2. DATE OF DEATH: 11-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI Hospital

C. Length of stay in Baltimore: 55 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15
D. STREET ADDRESS (If rural, give location): 1802 N Smallwood St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 16, 1872 | 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rae Herman ADDRESS: 1802 N Smallwood

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma. Primary Source undetermined. Metastases

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senile age.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 10-29-49

19B. MAJOR FINDINGS OF OPERATION: Metastatic Carcinoma.

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1949 *to* Nov 7, 1949 *that I last saw the deceased alive on* 11-7-1949 *and that death occurred at* 8:10 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Arnold Gruner M. D.

23B. ADDRESS: Sinai Hosp. Balto

23C. DATE SIGNED: 11-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-8-49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis

ADDRESS: 2100 Eutaw Pl

VS 150

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CERTIFICATE CORRECTED 11/18/49 ✓

G79,154 G79,154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL KAPLAN

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1828 East Dallo St
C. Length of stay in Baltimore: 42 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 1828 East Dallo St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 70 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during greater part of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | | Russia | |

13. FATHER'S NAME: Naftali

14. MOTHER'S MAIDEN NAME: Rebecca

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Type or Print) ADDRESS |
|---|---|---|
| | | Esther Kaplan 1828 E Dallo St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Coronary occlusion

DUE TO

(C) arteriosclerotic cardiovascular renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 19[illegible], *to* Nov 8, 19[illegible] *that I last saw the deceased alive on* Nov 7, 1949 *and that death occurred at* 2:20 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Abarbanel M.D. M. D. | 601 N. Monroe St. | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-8-49 | United Hebrew | Washington Blvd. Balt. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Jack Levine, Inc. | 2100-02 Eutaw Place |

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G79655

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

G79655

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) PAUL DESSER

2. DATE OF DEATH 11-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-16

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home

c. Length of stay in Baltimore 50 Yrs. ~~Mos.~~ ~~Days~~

D. STREET ADDRESS (If rural, give location) 3323 Woodland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 77 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor Dresser

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Isaac

14. MOTHER'S MAIDEN NAME Freida

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Rose Desser ADDRESS 3323 Woodland Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion - disease — INTERVAL BETWEEN ONSET AND DEATH Apr 18/49

DUE TO

(B) Arterio Sclerosis ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

CERTIFICATION APPROVED BY for DR. KAMMER
R S Fraser

(C)

M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr 18, 1949, to Nov 7, 1949, *that I last saw the deceased alive on* Oct 25, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Chas D Bubert M. D.

23B. ADDRESS 4803 Park Heights Ave

23C. DATE SIGNED Nov. 8. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11-8-49

24C. NAME OF CEMETERY OR CREMATORY Hebrew Mt. Carmel

24D. LOCATION (City, town, or county) (State) Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 8 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jos Levine, Inc. ADDRESS 210-02 Eutaw Place

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G79656

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

Registered No. G79656

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mitchell Damerick

2. DATE OF DEATH: Nov. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3920 Colespring Lane 15-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | | 37 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator
10B. KIND OF BUSINESS OR INDUSTRY: Shoe
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Not known
14. MOTHER'S MAIDEN NAME: Not known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Iona Damerick ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
Right occipital lobe.
INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location.)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: R S Fraker M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Nov. 8, 1949

24. BURIAL, CREMATION, REMOVAL (Specify): Burial
24A. DATE: 11-9-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Dalto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Reeves Inc
ADDRESS: 2100 Eutaw Pl

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79637 ✓ X 770.0 G79637

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-23991 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Mewshaw

2. DATE OF DEATH: 11/7/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elkridge, 27 Rural
D. STREET ADDRESS (If rural, give location): Box 335 Montgomery Rd.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | single | 11/7/49 | | | 30 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: James Mewshaw

14. MOTHER'S MAIDEN NAME: Mrs. Hazel Reinhardt Mewshaw

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Erythroblastosis fetalis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/7/49, 19__, *to* 11, 7, 49, 19__, *that I last saw the deceased alive on* 11/7/49, 19__, *and that death occurred at* 6:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Roy Mueller | Bon Secours Hospital Baltimore | 11-7-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 8-1949 | St. Augustine's Cem | Washington Blvd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Registrator Williams, M.D. | Thos. J. Kenny Inc. | 1600 Hollins St |

VS 150

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79658 ✓ G79658

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Dr. 1

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH ROGUS

2. DATE OF DEATH: 11/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 629 RAPPOLLA ST.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 629 RAPPOLLA ST. 26-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | MARRIED | 3/3/1900 | 49 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MACHINEST | | MD. | U.S.A. |

13. FATHER'S NAME: JOSEPH ROGUS

14. MOTHER'S MAIDEN NAME: SOPHIA STELMACH

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | NONE | ? | TILLIE ROGUS | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 hr. |
| DUE TO (B) | none | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/3, 1949, *to* 11/5, 1949, *that I last saw the deceased alive on* 11/5, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature], M.D. | 4613 Fern Ave. | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11/8/49 | SACRED HEART | BALTO. CO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | WILEY & ZEILER INC. | BALTO. MD. |

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G79659

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

199-8

Registered No. G79659

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Raleigh

2. DATE OF DEATH: 11-5-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 29yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1221 W. Lafayette Ave. 1 6 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | June 6- 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Tenn. | |

13. FATHER'S NAME: Abraham Raleigh

14. MOTHER'S MAIDEN NAME: Matilda Fitzgerald

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|---|
| | | | Baltimore City Hospitals Records: 4940 Eastern Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinomatosis, primary? | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-12- , 1949 *to* 11- 5- , 1949 *that I last saw the deceased alive on* 11-5- , 1949 *and that death occurred at* 10.05 pm *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. A. Hogan M. D. | Baltimore City Hospitals | 11-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-9-1949 | W. F. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Mrs Kate R. Williams | 322 N. Schroeder St. |

VS 150

55E

79660

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79660

1. NAME OF DECEASED (Type or Print): HERMINE JOHANA HAHN

2. DATE OF DEATH: 11-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for the Women of Md.
C. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pikesville (rural)
D. STREET ADDRESS (If rural, give location): 708 Reisterstown Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | 11-15-[illegible] (1889) | 59 | 11 / 20 | 1 / |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Roschen
14. MOTHER'S MAIDEN NAME: Louise A. Schroeder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO Undetermined cause

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pulmonary Edema; Diabetes Mel.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-31, 1949 *to* 11-5, 1949 *that I last saw the deceased alive on* 11-5, 1949 *and that death occurred at* 1:00A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. P. Benson Jr. M.D. | Women's Hosp. | 11-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 8/49 | Druid Ridge | Pikesville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | Losing Byers 5005 Pk. Heights |

VS 150

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G79661 ✓ G79661

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 610 Registered No.

1. NAME OF DECEASED (Type or Print): Charles Rusk

2. DATE OF DEATH: NOV 5 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8 07
D. STREET ADDRESS (If rural, give location): 1311 N. Carolina St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Separated | 9-6-96 | 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles Rusk
14. MOTHER'S MAIDEN NAME: Jobie L. Warden
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) ACUTE RENAL SHUT DOWN acute renal shutdown

DUE TO

(C) Multiple transfusions TRANSFUSIONS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Carcinoma of prostate.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/24/49 | B.P.H. & prostate | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/26, 19 49 *to* 11/5, 19 49 *that I last saw the deceased alive on* 11/5, 19 49 *and that death occurred at* 11:15 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John F. Hagan Jr. M. D. | JOHNS HOPKINS HOSPITAL | 11/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | State |
|---|---|---|---|---|
| Burial | 11/10/49 | Brots National | Baltimore | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | | Robert H. Young | 1532 E. Monument St |

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G79662 ✓ G79662

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 420.1

1. NAME OF DECEASED (Type or Print): Joseph Bowie.

2. DATE OF DEATH: 11/4/49.

3. PLACE OF DEATH: A. Baltimore City Maryland Balto.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1530 E. Madison St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

C. Length of stay in Baltimore: Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1530 E. Madison St

5. SEX: Male

6. COLOR or RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: Dec 3. 1878

9. AGE (In years last birthday): 70 yr. | Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter

10a. KIND OF BUSINESS OR INDUSTRY: Balto City

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Bowie

14. MOTHER'S MAIDEN NAME: Rachel Hammonds

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Katie Nelson ADDRESS: 804 E. Bond St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO

(B) Myocarditis

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 6, 1949, to Nov. 4, 1949, that I last saw the deceased alive on Nov. 4, 1949, and that death occurred at 8:30 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Alex L Lafferd M.D.

23B. ADDRESS: 822 N. Bond St

23C. DATE SIGNED: 11/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/8/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, town, or county) (State): B. A. County Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: Robert L. Young ADDRESS: 1532 E. Monument St

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bernice Hillsman Michaels

2. DATE OF DEATH: Nov. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1301 Park Ave.

c. Length of stay in Baltimore: 28 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ruxton
D. STREET ADDRESS (If rural, give location): Rider Hill Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 8, 1875
9. AGE (In years last birthday): 74 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richmond, Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Dr. John Albert Hillsman
14. MOTHER'S MAIDEN NAME: Mary Judith Blanton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Albert H. Michaels ADDRESS: Ruxton, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) myocarditis - Arteriosclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1, 1943 to Nov 7, 1949, that I last saw the deceased alive on Nov 7, 1949, and that death occurred at 11 45 P m., from the causes and on the date stated above.

23A. SIGNATURE: M. D. McNeely
23B. ADDRESS: 1403 Park Ave
23C. DATE SIGNED: 11-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/10/49
24C. NAME OF CEMETERY OR CREMATORY: Hollywood Cemetery
24D. LOCATION (City, town, or county) (State): Richmond, Va.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1949
REGISTRAR'S SIGNATURE: Thomas A. Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Mears and Son
ADDRESS: 825 N. Calvert St

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CERTIFICATE CORRECTED 11/9/49 ✓ X G79ont.4

G79ont.4

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mamie Agnes Baker

2. DATE OF DEATH: 11-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp
c. Length of stay in Baltimore: 57 yrs. (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Essex
D. STREET ADDRESS (If rural, give location): 1615 Doolittle Road #21

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | white | Widowed | June 2, 1893 | 56 years | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leo Harron
14. MOTHER'S MAIDEN NAME: Mamie Zoph

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Virginia A. Reed ADDRESS: 3317 Roberton

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: unknown several yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic cardiovascular disease — 7 years

DUE TO

(C) Hypertensive Cardiovascular disease — ? years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Mild diabetes, Cholelithiasis left hemiplegia

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION: Congestive changes Liver & Spleen
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 - 2, 1949, *to* 11 — 7, 1949 *that I last saw the deceased alive on* 11 - 7, 1949 *and that death occurred at* 2.30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louisa Caudles M.D.
23B. ADDRESS: Maryland Genal Hosp.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Funeral
24B. DATE: Nov. 10-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949
REGISTRAR'S SIGNATURE: [illegible] for Baltimore, Md.
25. FUNERAL DIRECTOR: Jos. J. Aker & Son
ADDRESS: 3001 Ky. Ave.

VS 150

61

G79665 G79665

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM HARRY WOOD

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3610 Clifton Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3610 Clifton Ave. 11-7-49

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 1873
9. AGE (In years last birthday) If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 76 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist
10B. KIND OF BUSINESS OR INDUSTRY: railroad
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas P. Wood
14. MOTHER'S MAIDEN NAME: Annie Mills
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 213-01-1738
17. INFORMANT: Mrs. H. L. Holland — ADDRESS: 4809 Coleherne Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac insufficiency, arteriosclerotic

DUE TO

cardio-vascular disease

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/25, 1949 *to* 11/6, 1949 *that I last saw the deceased alive on* 11/5, 1949, *and that death occurred at* 6.45P. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. H. Kemp M. D.
23B. ADDRESS: 3030 Edmondson Avenue.
23C. DATE SIGNED: 11/7/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/9/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM.J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

93D

G79666

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79666 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOLA VIRGINIA HAYNIE BEAN

2. DATE OF DEATH: Nov. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 41 S. Stricker St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 41 S. Stricker St. 19-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | divorced | Aug. 9, 1897 | 52 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Haynie | Lucy Brown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Constance Booker | 3319 Gwynn Falls Pkwy |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B) Arteriosclerotic heart disease — 3 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 5, 1946 *to* Nov. 7, 1949, *that I last saw the deceased alive on* 1:20 P.M. 11-8-49 *and that death occurred at* 1:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Morris B. Abrahams M. D. | 540 Fulton Ave. | 11-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/10/49 | Lorraine Cem. | Woodlawn, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Hunting [illegible] | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

G79667 ✓ G79667

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1949

Registered No.

1. NAME OF DECEASED (Type or Print): CARRIE EDITH THAWLEY

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2433 Barclay St.
c. Length of stay in Baltimore: 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2433 Barclay St. 12-03

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: July 31, 1865
9. AGE (In years last birthday): 84 yrs. (If under 1 Year: Months Days; If under 24 Hours: Hours Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Calvert Co., Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Joseph Smith
14. MOTHER'S MAIDEN NAME: Eliza Kelton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mrs. Grace Ostrander ADDRESS: 2433 Barclay St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: , unk
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Nov, 1949 *to* 8 Nov, 1949, *that I last saw the deceased alive on* 8 Nov, 1949 *and that death occurred at* 2 00 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jos B Cleveland Jr M. D.
23B. ADDRESS: 2843 St Paul
23C. DATE SIGNED: 8 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/10/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949
REGISTRAR'S SIGNATURE: Thomas J. Williams, III
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

931

G79668

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79668

BIRTH NO. 153 Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES S. KELLER

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 816 George St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 816 George St. 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Mar. 13, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| salesman | meats | Balto. Md. | |

13. FATHER'S NAME: Daniel E. Keller

14. MOTHER'S MAIDEN NAME: Earnestine Schmennor

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 216-05-4749 | Mrs. Elizabeth Keller | 816 George St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Asthenia — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO (B) Carcinoma of liver and intestines — 6 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 3, 1949 *to* Nov 8, 1949 *that I last saw the deceased alive on* Nov 8, 1949, *and that death occurred at* 9.30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr E W Coons M. D. | 1202 St Paul St | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/11/49 | Cathedral Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46E

G79669

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79669

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): OTTO-M.-THOMAS.

2. DATE OF DEATH: 7 November 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 106 S. Monastery Ave.

C. Length of stay in Baltimore: 76 years 3 mos. 19 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-07
D. STREET ADDRESS (If rural, give location): 106 S. Monastery Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | married | July 19, 1872 | 77 76. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| street paver. | street paving | Baltimore, Maryland | U. S. |

13. FATHER'S NAME: William Thomas

14. MOTHER'S MAIDEN NAME: Antonia Schwanger

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | unknown | Wife - Mrs Thomas | 106 S. Monastery |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-sclerosis. — years

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November, 1948 *to* November, 1949 *that I last saw the deceased alive on* 7 November 1949 *and that death occurred at* 9:50 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Goodman, M. D. | 1334 Sulphur Spring Road | 7 Nov 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Nov. 10-1949 | Western Cemetery. | Baltimore - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Charles J. Schwab | 3512 Frederick Ave. |

VS 150

94a

029649

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79670

Registered No.

1. NAME OF DECEASED (Type or Print): CATHERINE ELIZABETH RENNER

2. DATE OF DEATH: Nove. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6004 Glen Oaks Avenue
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6004 Glen Oaks Avenue 27-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Dec. 21, 1879 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | USA |

13. FATHER'S NAME: George M. Himmer

14. MOTHER'S MAIDEN NAME: Henrietta Schmidt

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | none | Dr. John Harry Renner 6004 Glen Oaks Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Coronary Occlusion | Immediate |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Hypertensive Heart disease | 1 year |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 4, 1948, *to* Nov. 5, 1949, *that I last saw the deceased alive on* Oct 20, 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. Renner | 4808 Harford Rd. | 11/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/9/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 8 1949 | | HENRY SANDER & SONS, INC. |

VS 150

931

G79671

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 G79671

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Leslie Charles Pollock

2. DATE OF DEATH: 11-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5713 Belair Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 44 Yrs. 10 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6, 27-34
D. STREET ADDRESS (If rural, give location): 6224 Everall Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | W. | Married | Jan. 8, 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Payroll Clerk | Bethlehem Steel Business | Baltimore Md. | U.S. |

13. FATHER'S NAME: Henry Michael Pollock

14. MOTHER'S MAIDEN NAME: Laura Virginia Mac Manus

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 213-09-1334 | Mrs. Mary Pollock | 6224 Everall Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Artery Disease (?)

DUE TO

(C)

CERTIFICATION APPROVED BY
For W. G. Helfrich
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 10-7, 1949, *that I last saw the deceased alive on* 10-7, 1949 *and that death occurred at* 9:10 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark R. English M. D. | 5713 Belair Rd. | 11-7-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/10/49 | Oak Lawn Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | [illegible] | HENRY SANDER & SONS, INC. | |

VS 150

94a

G79672 ✓ G79672

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Howard Smith

2. DATE OF DEATH Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1307 W. Lanvale St. 16-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | S | 10/-1/08 | 41 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | | Md. | |

13. FATHER'S NAME Thos Smith

14. MOTHER'S MAIDEN NAME [illegible] Wendy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | |

17. INFORMANT ADDRESS [illegible]

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (At, in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) therein and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Wm J. McCafferty M.D. | | Nov. 7, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/10/49 | [illegible] | [illegible] |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| MAR 8 1950 | [illegible] M.D. | [illegible] | [illegible] |

VS 151

130

G79673

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79673 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ZANNIE GARRETT

2. DATE OF DEATH: Nov. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 124 N. Exeter Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Divorced | 11/17/190- | 46 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Work | | Fla. | U. S. A. |

13. FATHER'S NAME: Willie Garrett

14. MOTHER'S MAIDEN NAME: Ellis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 194-01-7306 | [illegible] Sumner Wife Colored Sis | Chicago 111 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Miliary tuberculosis

DUE TO pulmonary tuberculosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death to my opinion resulted from natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Royer M.D. | | 11-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/8/49 | Mt. Auburn | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11/8/1949 | [signature] | Geo. H. Kelson | 1303 Pennsylvania Ave |

VS 151

13B

G79674

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 43

G79674 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Frank** **Marshall**

2. DATE OF DEATH **Nov. 7, 1949**

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1714 Druid Hill Ave.

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 1714 Druid Hill Ave. 14-07

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | | 69 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (a) Hypertensive Cardio-Vascular | |
| | DUE TO Disease | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CONDITION LAST | (b) | |
| | DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23a. SIGNATURE H. J. McCafferty M.D.

23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23c. DATE SIGNED Nov. 8, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Nov. 8, 1949

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Washington, D.C.

DATE RECEIVED BY LOCAL REGISTRAR NOV 8

REGISTRAR'S SIGNATURE Washington Funeral Home, Md.

25. FUNERAL DIRECTOR ADDRESS W. Ernest Jarvis Co. 1432-"U" st. N.W. Wash., D.C.

VS 151

G79675 ✓ G79675

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 1949

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Christian Brodie (James F. Brodie) | 2. DATE OF DEATH: 11/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: 18? (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-01
D. STREET ADDRESS (If rural, give location): Mt. St. Joseph's College

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Oct. 29, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Teacher | Xaverian Brothers | Boston, Mass. | U. S. A. |

13. FATHER'S NAME: Patrick Brodie (dec'd)
14. MOTHER'S MAIDEN NAME: Annie Splaine (dec'd)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | | Brother Bartholomew | Mt. St. Joseph's College |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic carcinoma —

DUE TO

(B) Site of origin undetermined

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 9/16 1949, *to* 11/7 1949 *that I last saw the deceased alive on* 11/8, 1949, *and that death occurred at* 9:5 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hubert J. Brickos M. D. | St. Agnes Hospital | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 10, 1949 | New Cathedral Cem. | Baltimore Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Chas. F. Evans & Son | ADDRESS: 116 W. Mt. Royal Ave. 55E

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G79676 ✓ G79676

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print): Clarence Albert Ramsay

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2706 E. Preston St. 803

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | Married | March 29, 1891 | 58 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | B. & O. R. R. | Baltimore | |

13. FATHER'S NAME: David Ramsay

14. MOTHER'S MAIDEN NAME: Estella M. Carroll

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 205-09-9480 | Marie B. L. Ramsay | 2706 E. Preston St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis
DUE TO
(B) Generalised arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Oct. 17, 1949, *to* Nov. 6, 1949, *that I last saw the deceased alive on* Nov. 6, 1949, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. K. Kaan M. D. | 1400 N. Caroline St. | Nov. 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-9-49 | Western Cemetery | Edmondson Ave. Balto. Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 8 1949

REGISTRAR'S SIGNATURE: T. Worthington Williams, M.D.

25. FUNERAL DIRECTOR: John P. Millington

ADDRESS: 1925 E. Oliver St

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83C

96177 Harrison ✓ X 416 G79177

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): DORIS MAY KING

2. DATE OF DEATH: NOV 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: 27 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WHITEHALL
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | SEPT 15, 1922 | 27 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | | BALTIMORE, MD. | USA |

13. FATHER'S NAME: THOMAS FREELAND

14. MOTHER'S MAIDEN NAME: BESSIE GRIFFIN ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | CHARLES KING | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rheumatic heart disease (MV) — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Multiple pulmonary emboli (complicating the rheumatic heart disease) — 3 days

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pregnancy, appox. 2 months

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* NOV 5, 1949, *to* NOV 8, 1949, *that I last saw the deceased alive on* NOV 8, 1949, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. F. Cox M. D. | Union Memorial Hospital | 11-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Nov 10-1949 | Burial | Wesley Chapel | Marlboro. Road, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | Howard S Markle | |

VS 150

95B

79678 X ✓ 50.0 G79678

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) Elizabeth F. Shaw | 2. DATE OF DEATH 11/8/49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa. B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2939 N. Charles St. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kingston |
| c. Length of stay in Baltimore Yrs. 1 Mos. mo Days | D. STREET ADDRESS (If rural, give location) 548 Charles Ave. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Oct. 30, 1862 | 87 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | White Hall Pa. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Oscar Lewis | Catherine Haines ✓ |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. W. Don Morrow | 2939 N. Charles St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

(B) arterio Sclerosis — ?

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Old age

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| No | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| [redacted] m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 1, 1949 *to* Nov 8, 1949 *that I last saw the deceased alive on* Nov 8, 1949 *and that death occurred at* 12:50 pm *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| B. L. Keyser, M. D. | Westminster Md | Nov 8 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/11/49 | Dodson Chapel | Pa. Townhill |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | Wm. J. Tickner & Sons | North & Pa. Aves |

VS 150

107

G79679

BALTIMORE CITY HEALTH DEPARTMENT 289.1

# CERTIFICATE OF DEATH

Registered No. G79679

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Morval (Sam) L. Doan

2. DATE OF DEATH: Nov. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2100 Barkley St. 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Dec 29-1904 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanic | | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| A Doan | Elsie M Sweetmore |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mary E Doan 1619 Poplar Grove St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fatty Degeneration, Liver.

DUE TO Myocardial Degeneration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. J. McCafferty M.D. | | Nov. 8, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Cremation | 11/10/49 | Portland | Portland Oregon |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Carrington Williams, M.D. | Wilson & Son | 1219 E Fayette St |

VS 151

1240

G79680

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79680

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Catherine Margaret Zink

2. DATE OF DEATH: 11/6/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1450 Battery Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1450 Battery Ave 24-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 3/24/1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Benjamin Chenowith | Margaret (Unknown) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Alice Weller | 1450 Battery Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Cardiac Failure | 1 day |
| DUE TO (B) | Arteriosclerosis Renal | 7 days |
| DUE TO (C) | Disease | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 10/20/49 to 11/6/49, that I last saw the deceased alive on 11/6, 19 49 and that death occurred at 1405 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph G. Earl Curtis M. D. | 609 Washington Blvd | 11/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/9/49 | Mt. Olivet | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

131a

79681 CERTIFICATE CORRECTED 11-9-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

G79681

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) HELEN INELDA SCANLAN | 2. DATE OF DEATH 11/8/49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-0 ✓ |
| c. Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 1540 Windemere Ave # 18 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widow | Sept [illegible] | 53 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | | New York | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank I. Clark | Mary Pitcher ✓ |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive Cardiovascular Disease

DUE TO

(C) Rheumatic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| - m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/6 *19*49, *to* 11/8, *19*49, *that I last saw the deceased alive on* 11/7, *19*49 *and that death occurred at* 6:25 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Black Jr. M. D. | Maryland General | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/10/49 | Pikesville National | Cemetery Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams M.D. | Wilson Cook Inc | 1214 St Paul St |

VS 150

30E

67-96-82

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

194 Registered No.

67-96-82

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH C. LOTMAN

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3418 Noble St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3418 Noble St. 26-44

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | July 20, 1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md. | |

13. FATHER'S NAME: George Rudolph Honeman

14. MOTHER'S MAIDEN NAME: Mary M. Hellman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Margaret Lotman | 3418 Noble St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Senility | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) | |
| | DUE TO (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Coronary Thrombosis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* August, 1949, *to* Nov 8, 1949, *that I last saw the deceased alive on* Nov 1, 1949, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Jackson M. D. | 3400 E. Baltimore | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/11/49 | Holy Redeemer | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

737

G79683

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79683

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Drena Rubin

2. DATE OF DEATH 11/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12
D. STREET ADDRESS (If rural, give location) 3604 Park Heights Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto General

c. Length of stay in Baltimore 30 Yrs. ~~Mos. Days~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | | 84 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Felix

14. MOTHER'S MAIDEN NAME Hannah

15. HAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Lilly Lozinsky ADDRESS 3523 Park Hgts Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary thrombosis with myocardial infarction due to acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO

(B) Not noted on this or previous sheets

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2:30 PM 11/8, 1949, *to* 10:15 PM 11/8, 1949, *that I last saw the deceased alive on* 11/8 1949, *and that death occurred at* 10:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Katherine V. Kramer, M.D.

23B. ADDRESS West Balto. Gen. Hosp.

23C. DATE SIGNED 11/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11-9-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR NOV 9 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Jack Reeves Inc ADDRESS 1100 Eutaw Pl

VS 150

937

AB-133193

✓ 764.0

G79,684

G79,684

BIRTH NO. 49-22758

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Shirley Wood

2. DATE OF DEATH: 11-4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 24 N. Mount St. 9 o ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | N | Single | Oct. 19- 1949 | | 16 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willard Wood

14. MOTHER'S MAIDEN NAME: Shirley Ashby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:

17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intussception (ileocolic)

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

CERTIFICATION APPROVED BY
For: C. J. Lubinski, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4 , 1949 *to* 11-4 , 1949, *that I last saw the deceased alive on* 11-4 , 1949, *and that death occurred at* 12.22 pm, *from the causes and on the date stated above.*

23A. SIGNATURE: C. Cooper M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-5-1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/9/49 | Mt. Auburn Cem. | Baltimore, Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Charles G. Cooper
ADDRESS: 512 Carrollton Av

VS 150 To be approved by the Medical Examiner

122C

9685

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. 679685

1. NAME OF DECEASED (Type or Print) James Matthews

2. DATE OF DEATH 11-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. CITY OR TOWN Baltimore (If outside corporate limits, write RURAL, and give township) 17-01

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 807 - Penna - ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | W | 5/28/1891 | 58 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer

10B. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Matthews

14. MOTHER'S MAIDEN NAME Alice Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO 212-05-3426

17. INFORMANT ADDRESS Inez McCall-326 N. Monroe St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tbc. advanced bilateral

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-3 19 49 *to* 11-5 19 49 *that I last saw the deceased alive on* 11-5 19 49 *and that death occurred at* 0[illegible] A m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm Uhlmann M. D.

23B. ADDRESS Univ. Hosp.

23C. DATE SIGNED 11/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11/9/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 9 1949

REGISTRAR'S SIGNATURE Hunter for Williams, MD

25. FUNERAL DIRECTOR ADDRESS Charles G. Cooper-512 W. Carrollton Av

VS 150

120

To Be Approved - CERTIFICATE CORRECTED 11-23-49

G79686

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79686

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MILDRED KELLER LYNCH

2. DATE OF DEATH: 11-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland NORTHWOOD APTS.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4220 LOCH RAVEN BLVD

C. Length of stay in Baltimore: ALL HER LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE 27-09
D. STREET ADDRESS (If rural, give location): 4220 LOCH RAVEN BLVD.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED
8. DATE OF BIRTH: APRIL 9, 1906 1903
9. AGE (In years last birthday): 46 43
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERIC-TYPIST
10B. KIND OF BUSINESS OR INDUSTRY: MARITIME COMMISSION

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE F. KELLER

14. MOTHER'S MAIDEN NAME: Ellen V. Mae Keller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-22-6212

17. INFORMANT (DAUGHTER) ADDRESS: MRS. JEAN LIVESAY - 1050 SHEFFIELD RD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE CARDIO-VASCULAR DISEASE. — 10 YRS.

DUE TO

(C) BRONCHIAL ASTHMA — 15 YRS.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For J. R. DAVIS
B. Brashear M.D.

19A. DATE OF OPERATION: NONE

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID ACCIDENT OCCUR? (Specify city, town, or county, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-29, 1949 *to* 7-6, 1949 *that I last saw the deceased alive on* 7-6, 1949 *and that death occurred at* ? *m., from the causes and on the date stated above.*

23A. SIGNATURE: Arthur Karlquist M.D.
23B. ADDRESS: 4230 Loch Raven Blvd.
23C. DATE SIGNED: 11-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24B. DATE: Nov. 9, 1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem. Mausoleum
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Miles Amoreau
ADDRESS: 4510 Liberty Heights Ave.

VS 150

931

G79687

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79687

1. NAME OF DECEASED (Type or Print): William F. Ward
2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2885 Kinsey Ave. 20-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Dec. 5th 1915 | 33 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Crane Operator | Bethlehem Steel Co. | Kentucky | U.S.A. |

13. FATHER'S NAME: George Ward
14. MOTHER'S MAIDEN NAME: Sarah ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 403-12-6784 | Mrs Anna Ward | 2885 Kinsey Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Acute Coronary Insufficiency due to

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Sclerosis of Coronary Ostia due to

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: R S Fisher M.D. | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED: Nov. 8, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. loth 1949 | Mt. Olivet Cem. | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Wells Funeral Home | ADDRESS: 4510 Liberty Heights Ave

VS 151

201

79688 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 79688

1. NAME OF DECEASED (Type or Print): MARTIN MATHEW Mc DONOUGH
2. DATE OF DEATH: NOV. 7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Balto., Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 10 N. Clinton Ste.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 10 N. Clinton Ste. 26-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | June-10-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Balto. City | Balto., Md | |

13. FATHER'S NAME: Patrick Mc Donough
14. MOTHER'S MAIDEN NAME: Mary Sullivan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs. Annabelle, 10 N. Clinton St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Cardiac Dilatation | 1 dy |
| DUE TO (B) | Chronic Nephritis | 20 years |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 2/4/, 19[illegible] *to* 11/7, 1949, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S C Feldman M. D. | 1445 Park Ave | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 10-49 | Sacred Heart | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | John G. Connelly | 418 Eastern Ave. Balto. 2, Md. |

VS 150

97

G79689

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 17

Registered No. G79689

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | CHARLOTTE E. FRANK. |
| 2. DATE OF DEATH | Nov 2, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 1022 W. 38th St. |
| c. Length of stay in Baltimore (Yrs. Mos. Days) | Life |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Maryland |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 1022 W. 38th St. 13-07 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | Dec 27 1893 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Maryland. | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm. K. Smith | Elizabeth E. Smith |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Charles W. Frank | 1022 W. 38th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

(B) with Metastasis —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Nov 46 to Nov 7, 1949, that I last saw the deceased alive on Nov 7, 1949, and that death occurred at 10 P m., from the causes and on the date stated above.

| 23. SIGNATURE | 23A. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James L. Wardlaw M. D. | 3900 Alameda Blvd. | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 11/49 | Greenmount | Carroll Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | Austin E. Donovan | 3818 Roland Ave |

VS 150

48a

G79690

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79690

1. NAME OF DECEASED (Type or Print): EMMA E. REXROTH.

2. DATE OF DEATH: Nov 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTO MD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3030 REMINGTON AVE.
c. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3030 REMINGTON AVE 12-07

5. SEX: FEMALE | 6. COLOR OR RACE: WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW

8. DATE OF BIRTH: DEC 19, 1864 | 9. AGE (In years last birthday): 84 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —

17. INFORMANT: MRS. IDA B. REIDER
ADDRESS: 3030 REMINGTON AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V. Dis — INTERVAL BETWEEN ONSET AND DEATH: Several yrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 9 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edward L. Hamman M. D. | 23B. ADDRESS: 4017 Falls Rd. | 23C. DATE SIGNED: 11/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 24B. DATE: NOV 9, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE | 24D. LOCATION (City, town, or county) (State): PIKESVILLE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Austin E. Donovan
ADDRESS: 3818 Roland Ave

VS 150

93D

C79691

BALTIMORE CITY HEALTH DEPARTMENT 196 Registered No. C79691

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ADA ESTELLE MALLONEE.

2. DATE OF DEATH: Nov 8, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1304 Morling Ave

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1304 Morling Ave. 3-08

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Jan 2, 1907
AGE (In years last birthday): 42
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady
10B. KIND OF BUSINESS OR INDUSTRY: Sandler Dept Store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: George K. Jones.
14. MOTHER'S MAIDEN NAME: Jennie E. Townsend.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 218-07-0149
17. INFORMANT: Jennie E. Jones ADDRESS: 1304 Morling Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fibrosarcoma left shoulder girdle — INTERVAL BETWEEN ONSET AND DEATH: 3/1/48

DUE TO

(B) Metastases to lungs — a few months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 10/26/48
19B. MAJOR FINDINGS OF OPERATION: Fibrosarcoma left shoulder guidle
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/20, 1948, to 11/8, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23A. SIGNATURE: Conrad Wallenstein M.D.
23B. ADDRESS: 878 W 36th St.
23C. DATE SIGNED: 11/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 11/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Windsor Mill Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Euston E. Donovan ADDRESS: 3818 Roland Ave

VS 150

55B

G79692

BIRTH NO. H-91832

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

37 Registered No. G79692

1. NAME OF DECEASED (Type or Print): Pamela Louise Kyler

2. DATE OF DEATH: nov. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1015 W. Lanvale Street
c. Length of stay in Baltimore: 2 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1015 W. Lanvale Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Colored | ------ | Oct. 18, 1947 | 2 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ------ | ------- | Baltimore, Maryland | |

13. FATHER S NAME: Leighton Kyler

14. MOTHER S MAIDEN NAME: Lois Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: Mr. Leighton Kyler 1015 W. Lanvale S

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Spinal Cord tumor (Congenital) — Birth
DUE TO
(B) Epileptic Seizures — 11-2-49
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2, 1949, to 11-7, 1949, *that I last saw the deceased alive on* 11-7, 1949, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D. | 23B. ADDRESS: 824 Hamburg | 23C. DATE SIGNED: 11-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Nov. 9, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem. | 24D. LOCATION (City, town, or county) (State): Baltimore Co.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949

REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Holland Funeral Home 1631 D.H.Ave.

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G79693

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79693

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Terry

2. DATE OF DEATH: 11-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2612 Huron St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 49 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Winans 25-33
D. STREET ADDRESS (If rural, give location): 2612 Huron St Mt. Winans

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Col | widow | 6-12-1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY: domestic

11. BIRTHPLACE (State or foreign country): Kingsgorge Co. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Washington

14. MOTHER'S MAIDEN NAME: Annie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO

17. INFORMANT: Sadie Fields ADDRESS: 2612 Huron Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerosis — 4 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | 0 | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| 0 | 0 | 0 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 0 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 0 |

22. *I hereby certify that I attended the deceased from* 10-10-49 19__, *to* 11-7-49, 19__, *that I last saw the deceased alive on* 11-6-49, 19__, *and that death occurred at* 5 PM *m., from the causes and on the date stated above.*

23A. SIGNATURE: F. N. Gardner M.D.

23B. ADDRESS: 1524 Druid Hill ave

23C. DATE SIGNED: 11-8-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II/IO/1949 | Mt Arburn Cemetary | Baltimore Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Elroy O. Wilson 1000 Brantly Ave

VS 150

94a

G79694

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

29-4

G79694

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Fussellbaugh

2. DATE OF DEATH: Nov 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 712 Park Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 712 Park Ave 11 0 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | single | June 29 1870 | 79 | 4 | 9 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto. Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. H. B. Fussellbaugh

14. MOTHER'S MAIDEN NAME: Sarah Hall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Dr Corbin Street ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anemia, aplastic.

DUE TO

ANTECEDENT CAUSES

(B) Senility

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NO

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Feb, 1949 *to* 8 Nov, 1949, *that I last saw the deceased alive on* Nov 8, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Corbin Street M. D.

23B. ADDRESS: 712 Park Ave

23C. DATE SIGNED: 8 Nov 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Interment

24B. DATE: Nov. 10. 44

24C. NAME OF CEMETERY OR CREMATORY: Balto. Cemetery

24D. LOCATION (City, town, or county) (State): North ave & Gay St.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John O. Mitchell Sons ADDRESS: 1900 Eutaw Pl.

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G79695 ✓ X 59 0 G79695

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James C. Schneider

2. DATE OF DEATH November 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Tenn.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Knoxville
D. STREET ADDRESS (If rural, give location) Dutch Valley Rd.

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 7-11-49 | | 3 mo. | 27 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Tenn. | |

13. FATHER'S NAME LESLIE Schneider

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Truncus Arteriosus — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov 8, 1949 | Pulmonary atresia | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-5 19~~49~~ *to* 11-8 19~~49~~ *that I last saw the deceased alive on* 11-8 19~~49~~ *and that death occurred at* 4:55 P. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Russell Sasser M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11/11/49 | Greenwood | Knoxville Tenn |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Signature for Williams, M.D. | John D Mitchell & Son | 157 NE 900 E Estate Fla. |

VS 150

G79696 CERTIFICATE CORRECTED 11-21-49 ✓ G79696

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John DiCarlo

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp.
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt, more 27-18
D. STREET ADDRESS (If rural, give location): 3325 W. Belvedere Ave.

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: MAY 1, 1888
9. AGE (In years last birthday): 61 6 2 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Md tailoring Co.
10B. KIND OF BUSINESS OR INDUSTRY: Tailor
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Vincent DiCarlo
14. MOTHER'S MAIDEN NAME: angela marconi

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Rose DiCarlo ADDRESS: 3325 W. Belvedere Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) hypertensive cardio-vascular disease — 10 yrs.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-7, 1949 *to* 11-8, 1949 *that I last saw the deceased alive on* 11-8, 1949 *and that death occurred at* 10.50 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Burton V. Lech M.D. M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 11-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/11/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county), (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Edwardson
ADDRESS: 937 Hollins St.

VS 150

G79697

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79697

1. NAME OF DECEASED (Type or Print): Isaac Madison

2. DATE OF DEATH: Nov-6-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1210 Mc Elderry Court

c. Length of stay in Baltimore: 12 yrs (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 1210 Mc Elderry Ct 5-01

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): Married
8. DATE OF BIRTH: Apr 1-1917
9. AGE (If years, last birthday): 32 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Un Known
10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Winnsboro S. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Theodore Madison
14. MOTHER'S MAIDEN NAME: Lucille Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None

17. INFORMANT: Jessie Madison ADDRESS: 1210 Mc Elderry Ct

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-10-, 19[illegible] *to* 11-6-, 19[illegible], *that I last saw the deceased alive on* 11-6-, 1949, *and that death occurred at* 10:[illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. A. Berry, M.D.
23B. ADDRESS: 1420 E. Chase St
23C. DATE SIGNED: 11-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE: 11-9-49
24C. NAME OF CEMETERY OR CREMATORY: Winnsboro
24D. LOCATION (City, town, or county) (State): S Carolina

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 1412 E. Preston St

VS 150

G79698 G79698

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mary Gregerson

2. DATE OF DEATH Nov 6 - 1949

3. PLACE OF DEATH: A Baltimore City, Maryland Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2326 Guilford ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-04

c. Length of stay in Baltimore 40 yrs Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2326 Guilford ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | Col | Widow | Mar. 15-1879 | 70 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | — | Virginia | U S |

13. FATHER'S NAME Beverly Thornton

14. MOTHER'S MAIDEN NAME Martha ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | none | Mrs Mary Thomas | 2326 Guilford ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* Oct. 30, 1949, to Nov. 6, 1949, *that I last saw the deceased alive on* Nov. 6, 1949, *and that death occurred at* 4:15 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas J. Greenman M.D. | 2329 Guilford ave | Nov. 8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11-9-49 | Mt Calvary Fem A.A. Co | | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | Rayner Sanders | 832 1412 E. Preston St |

VS 150

G79699

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79699

1. NAME OF DECEASED (Type or Print): Rev. Richard R. W. Jackson
2. DATE OF DEATH: Nov. 6 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 5303 Belmore Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 27-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | C | W | [illegible] | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Minister | | [illegible] | |

13. FATHER'S NAME: Wm. Jackson
14. MOTHER'S MAIDEN NAME: [illegible]

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | [illegible] | [illegible] Belmore Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Larynx | about 2 yrs |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 29 1949 *to* Nov. 6 1949, *that I last saw the deceased alive on* Nov. 4 1949, *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Julius C. Bleuck, M. D. | 5356 Reisterstown Rd | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/10/49 | [illegible] Auburn | [illegible] |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | [illegible] Washington Williams, M.D. | [illegible] | [illegible] Pennsylvania Ave. |

VS 150

47a

G79700

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

111

G79700

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LUCIOUS F. McGOWAN

2. DATE OF DEATH: Nov. 8-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 610 S. Payson St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: 24 Yrs. 4 Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 610 S. Payson St 20-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | May 2-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Ret. Polisher | Stove Mfg. | Virginia | U.S. |

13. FATHER'S NAME: John W. McGowan

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 216-10-7383

17. INFORMANT: Mrs. John McGowan ADDRESS: 610 S Payson St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 Yrs.

DUE TO

(B)

DUE TO

(C) Carcinoma of Prostate

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Nov 1, 1948 *to* Nov. 8, 1949 *that I last saw the deceased alive on* Nov 8, 1949 *and that death occurred at* 6 A. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert Kerwisch M. D. | 1934 Wilkens Ave Baltimore 23, Md | Nov. 8, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 10-49 | Glove Landing Cem. | Glove Landing Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 8 1949 | Tunstall Williams, M.D. | Geo L. Berger Jr | 512 Hollins St |

516

mailed 23 Dec

G79701

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79701

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Horace Demby

2. DATE OF DEATH: 11-7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 741 Sarah Ann St

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 74 Sarah Ann St. 4-0 W

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | C | married | Mar. 22, 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Labour | | Eastern Shore, Md. | U.S.A. |

13. FATHER'S NAME: Robert Demby.

14. MOTHER'S MAIDEN NAME: Bell Parker.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Rosie Cornish. | 741 Sarah Ann. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6/10, 19 49, *to* 11/6, 19 49, *that I last saw the deceased alive on* 11/6, 19 49, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Cornish M. D. | 75 Conant St | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 10, 1949 | Mt. Auburn | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 3228 Edmondson Ave |

VS 150

93D

G79702 ✓ G79702

G79702 BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 174

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Sarah M. Clayton. | 2. DATE OF DEATH: 11-7-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 605 N. Carollton Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 605 N. Carollton Ave
c. Length of stay in Baltimore: 9 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 605 N. Carollton Ave. 16-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | C | Widow | November 18, 1874 | 74 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Floyd County, Va. | U.S.A. |

13. FATHER'S NAME: Wiley Thomas
14. MOTHER'S MAIDEN NAME: Mary Smith,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT: Bessie Jolley. ADDRESS: 605 N. Carollton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Ca. of Uterus | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertension Type H.D. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | none | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| none m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/7 , 1946, *to* 11/7 , 1949, *that I last saw the deceased alive on* 11/7 , 1949, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lovan B Bikes M.D. | 601 N.C elhoun St. | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 10, 1949 | Roanoke Va | Roanoke Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Entered for Williams, M.D. | Mrs Katie R Williams | Schroeder St |

VS 150

48B

G79703

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79703

1. NAME OF DECEASED (Type or Print): MOLLIE J. Johnson? Mrs. ?

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1229 E. Biddle, St.
c. Length of stay in Baltimore: 1 WK. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 10-01
D. STREET ADDRESS (If rural, give location): 1229 E. Biddle St.

5. SEX: F
6. COLOR OR RACE: C.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Nov. 2, 1887
9. AGE (In years last birthday): 62 61
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WARREN COUNTY N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: CALIER WILLIAMS
14. MOTHER'S MAIDEN NAME: MILLISA ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: CHARLES JONES ADDRESS: 1229 E. Biddle St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Asthenia — 1 day.
DUE TO
(C) Myocarditis & Pericarditis — Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/6/49 *to* 11/8/49, 19__ *that I last saw the deceased alive on* 11/8, 19 49 *and that death occurred at* 6:35 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE, M. D.: Chas R. Blake
23B. ADDRESS: 1603 E. Caroline
23C. DATE SIGNED: 11-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24B. DATE: 11-9-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. OLIVE
24D. LOCATION (City, town, or county) (State): NORFOLK, VA.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Temporary for Williams, M.D.
25. FUNERAL DIRECTOR: Joseph B. Rocks, Jr. ADDRESS: 1304 N. Central Ave

VS 150

93D

G79704

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79704 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Magdalene (Della) duFrainoi

2. DATE OF DEATH: Nov. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3320 duPont Ave.
c. Length of stay in Baltimore: 55 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 3320 duPont Ave., 27-16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | Widow | Aug. 23, 1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | St. Mary's County, Md. | U.S.A. |

13. FATHER'S NAME: Richard Long,

14. MOTHER'S MAIDEN NAME: Harriet Bailey,

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | Miss Frances duFrainoi, 3320 duPont Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Nov 2/49
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 2, 19 49, *to* 11/7, 19 49, *that I last saw the deceased alive on* 11/7 19 49, *and that death occurred at* 10.50 m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward Bubal M. D. | 4803 Park Heights Ave. | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/10/49 | Cedar Hill Cemetery | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | C. Vernon Lemmon | 4611 Pk. Heights Ave. |

VS 150

Huntington Williams, M.D.

83a

G79705 ✓ G79705

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 420 D Registered No.

1. NAME OF DECEASED (Type or Print): JOHN HENRY HOKAMP

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1649 Darley Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1649 Darley Ave. 8-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Aug. 23, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Rectifier | Amer. Brewery | Baltimore, Md. | U.S. |

13. FATHER'S NAME: Anthony Hokamp

14. MOTHER'S MAIDEN NAME: Catherine Scharf

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | | Mrs. Marie Kaufman, 1134 Wilmot Court |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart Disease

DUE TO

(B) Congestive Failure

DUE TO

(C) Senile Dementia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| INTERVAL BETWEEN ONSET AND DEATH |
|---|
| ? |
| 1 mo. |
| ? |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 1949, *to* Nov. 6, 1949, *that I last saw the deceased alive on* 4 Nov, 1949, *and that death occurred at* 10.30 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. Schaefer, M. D. | 714 E Preston | 9 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/10/49 | Holy Redeemer Cemetery | 4430 Belair Rd. Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 9 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 150

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G79706

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

704.0

G79706 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Rice

2. DATE OF DEATH: Nov. 7 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Calvert
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sunderland
D. STREET ADDRESS (If rural, give location) Calvert Co.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | | 3-23-94 | 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Rice
14. MOTHER'S MAIDEN NAME: Lomah Smith
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Agranulocytosis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Sulfapyridine reaction (over)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/31/26, 19[illegible] *to* 11/7, 1949, *that I last saw the deceased alive on* 11/7, 1949, *and that death occurred at* 3[illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip S. Hagley M. D. | JOHNS HOPKINS HOSPITAL | 11-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 11-49 | Mt. Hope | Calvert County, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Charles H. Alexander, 1200 McCulloh St.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 819.4

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cyrus James N-809.2

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington, D.C.
D. STREET ADDRESS (If rural, give location): 58 H. St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | | 9/25/29 | 20 yrs | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Billiard Caller
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Hartwell
14. MOTHER'S MAIDEN NAME: Ruth Jamer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Ruth Dunbar ADDRESS: 58 H St. N.W. D.C.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Exsanguination — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Avulsion, right arm.
DUE TO
(C) Multiple rib fractures. Compound comminuted fracture L mandible

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Washington Blvd., Relay Md. 500 ft. south of Sutton Rd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 9, 1949 3:24 A. m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Auto into pole (Passenger)

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. J. Mc Cafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Nov. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 11/9/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State): Washington, D.C.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Cavan Memorial Funeral Service ADDRESS: D.C.

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G79708 G79708

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob A. Breeden

2. DATE OF DEATH: November 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400 W. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aged Homme and Aged Mens Homme

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-02
D. STREET ADDRESS (If rural, give location) 1400 W. Lexington St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: December 1859
AGE (In years last birthday): 89
If under 1 Year: Months 11 Days 8
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inmate
10B. KIND OF BUSINESS OR INDUSTRY: Home for Aged
11. BIRTHPLACE (State or foreign country): Calvert County, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Breeden
14. MOTHER'S MAIDEN NAME: Jane Nattingly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT L. H. Read ADDRESS 1400 W. Lexington Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) arteriosclerotic Myocarditis
DUE TO
ANTECEDENT CAUSES
(B) arteriosclerotic Cardio-Vascular
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO disease, generalized
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 8, 1949, to Nov. 7, 1949, that I last saw the deceased alive on Nov. 7, 1949, and that death occurred at 10:45 a. m., from the causes and on the date stated above.

23A. SIGNATURE: Maryland Edward Day M. D.
23B. ADDRESS: 4-E-33rd St
23C. DATE SIGNED: November 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/10/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949
REGISTRAR: Leon Abrams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

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G79709 ✓ G79709

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AUGUSTA E. HEIMILLER

2. DATE OF DEATH Nov. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1774 Montpelier Street

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-07

D. STREET ADDRESS (If rural, give location) 1774 Montpelier Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | May 25, 1853 | 96 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | washington, D.C. | USA |

13. FATHER'S NAME Alfonse Hilton

14. MOTHER'S MAIDEN NAME Sarah Anderson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT |
|---|---|---|
| no | none | 1774 Montpelier Street - R Mrs Gertrude Thumser |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senility

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8½ yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4-26- , 1941 *to* 11-7- , 1949 *that I last saw the deceased alive on* 11-7 , 1949 *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melton C. Lang M. D. | 2117 Belair Rd | 11-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/10/49 | Glenwood Cemetery | Washington, D.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 10 1949 | | HENRY SANDER & SONS, INC. |

VS 150

BALTIMORE - 13, MARYLAND 93D

G79710 ✓ G79710

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 491

Registered No.

1. NAME OF DECEASED (Type or Print): John R. Majors

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 21 S. Exter St. 3-02

c. Length of stay in Baltimore: 6 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | Oct. 3, 1898 | 51 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Huckster | Self Employed | Baltimore, Maryland | USA |

13. FATHER'S NAME: William E. Majors

14. MOTHER'S MAIDEN NAME: Lizzie L. Word

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | |

17. INFORMANT: Mrs. John G. Starr — ADDRESS: 1713 N. Collington Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Broncho-pneumonia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: [signature] M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/12/49

24C. NAME OF CEMETERY OR CREMATORY: Rockwood Pondwood

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sassaba Funeral Home — ADDRESS: 1440 Park Ave

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 44

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HARRY Z. MEGINNIS

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1930 Linden Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 1930 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan. 29, 1886 | 63 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| agent | manufacturers | Balto. Md. | |

13. FATHER'S NAME: John R. Meginnis

14. MOTHER'S MAIDEN NAME: Mary V. Ziegler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs. Frieda T. Meginnis | 1930 Linden Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 3½ mos.
DUE TO
(B) Hypertensive - Cardio Vascular Renal Disease — 1 year
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) Diabetes Mellitus — 12 Years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 1949 *to* 8 Nov. 1949, *that I last saw the deceased alive on* 8 Nov. 1949, *and that death occurred at* 9:15 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Laurista L. Brown M. D. | 1938 Linden Ave | 9 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/11/49 | Druid Ridge Cem. | Pikesville, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: [illegible]
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. Nov 7-49

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Julia M. Branch

2. DATE OF DEATH 10-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1327 N Gilmor St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1327 Gilmor St.

C. Length of stay in Baltimore 30 Yrs. Mo. Days

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)
A. State Md. B. County City.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01
D. STREET ADDRESS (If rural, give location) 1327 Gilmor St.

5. Sex F. | 6. COLOR OR RACE Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH June 7 1889 | 9. AGE (In years. If under 1 year, last birthday) 60 | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cumberland Co Va | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Richard Wilson

14. MOTHER'S MAIDEN NAME Henrietta Giles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Lucille Graham ADDRESS 1327 Gilmor St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 2 days |
| DUE TO (B) | Aortic Insufficiency (Arteriosclerotic) | 3-4 Years |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Nephritis Hypertension Partial Hemiplegia | 3-4 Yrs |

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Sept 1949 *to* Nov 7, 1949, *that I last saw the deceased alive on* 11/6, 1949, *and that death occurred at* 11 40 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Ralph Young M. D. | 23B. ADDRESS 1424 E Monument St | 23C. DATE SIGNED 11/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 10-11-49 | 24C. NAME OF CEMETERY OR CREMATORY Arbutus | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 10 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR A. Halstead | ADDRESS 918 - 131a Druid Hill Ave.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 00 ✓

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Dolores Hall

2. DATE OF DEATH November 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4619 Schenley Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-14
D. STREET ADDRESS (If rural, give location) 4619 Schenley Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | MAY 30, 1916 | 33 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Maryland. | U.S. |

13. FATHER'S NAME JOSEPH EMRINE

14. MOTHER'S MAIDEN NAME MARY WINKLER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | A. RICHARD HALL | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years.

DUE TO —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) —

DUE TO —

(C) —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* January 28, 1949, to Nov. 8, 1949, *that I last saw the deceased alive on* Nov. 8 1949, *and that death occurred at* 3:20 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Darius A. Faggott M. D. | 3812 Greenmount Ave | Nov. 8, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-11-1949 | PARKWOOD | BALTO. MD. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Mary Lee Matthews, M.D.

25. FUNERAL DIRECTOR: H. W. JENKINS & SONS CO. ADDRESS: 4905 YORK RD.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4200

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) WALTER LINSKY

2. DATE OF DEATH 11/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-01
D. STREET ADDRESS (If rural, give location) 1273 HULL ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | separated | MAY 6 1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| STEVEDORE | | BALTIMORE | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ANTHONY LINSKY | SOPHIE NICHLAS |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | CHRISTINE LINSKY, 1468 Reynolds ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema
DUE TO
(B) Congestive heart failure
DUE TO
(C) ASHD & HCVD

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/4 19 49 *to* 11/9 19 49 *that I last saw the deceased alive on* 11/9 19 49 *and that death occurred at* 12 55 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Krakauer M.D. | Sinai Hospital | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-11-49 | Holy Rosary | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Charles F. Dill | 1501 E. Fort Ave |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 7544 D Registered No.

1. NAME OF DECEASED (Type or Print): Alan C. Sabel

2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE N. Y. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bronx
D. STREET ADDRESS (If rural, give location) 2690 Webb ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 3-24-46 | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | N. Y. | |

13. FATHER'S NAME: Julius Sabel

14. MOTHER'S MAIDEN NAME: Pauline Sendall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

(B) Thoracotomy, right — 48 hrs.

DUE TO

(C) Tetralogy of Fallot — Congenital

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/7/49 | Tetralogy of Fallot | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-1 1949 *to* 11-4 1949, *that I last saw the deceased alive on* 11-9 1949, *and that death occurred at* 10 20P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard L. Griffith M. D. | JOHNS HOPKINS HOSPITAL | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11-10-49 | New York City | New York City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 26. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 10 1949 | Hunterfor Williams, M.D. | Jack Sears Inc - 2170 Eastern Pkwy |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) GERTRUDE C. WISSNER

2. DATE OF DEATH Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3125 MARECO AVE
C. Length of stay in Baltimore ALL OF LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3125 MARECO AVE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE, MARYLAND
D. STREET ADDRESS (If rural, give location) 3125 MARECO AVE 8-01

5. SEX FEMALE
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED (Specify)~~
8. DATE OF BIRTH Feb. 28, 1888
9. AGE (In years last birthday) 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE
11. BIRTHPLACE (State or foreign country) UNITED STATES
12. CITIZEN OF WHAT COUNTRY? SAME
13. FATHER'S NAME John N
14. MOTHER'S MAIDEN NAME MARGARET AMHRIEN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MARY R. SERIO ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — (INTERVAL BETWEEN ONSET AND DEATH) 10 hours
DUE TO
(B) Sarcoma left thigh — 6 mo.
DUE TO
(C) Hypertensive Cardio Vascular D. — 1 year

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1938 19__, *to* Nov 8 1949 *that I last saw the deceased alive on* 11-9 1949, *and that death occurred at* 5:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE William L. Fearing M.D.
23B. ADDRESS 3025 Bolai Road
23C. DATE SIGNED 11-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Nov 11-1949
24C. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery
24D. LOCATION (City, town, or county) (State) North Over Rose St. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 10 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Joseph Farace Inc.
ADDRESS 2013 Greenmount ave

VS 150

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79717

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Baby Webb 760.0

2. DATE OF DEATH 11/5/42

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore 7 hrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2612 Huron St - Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto, 25-42
D. STREET ADDRESS (If rural, give location) 2612 Huron St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Infant | 11/4/42 | | | 7 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto, Md. | |

13. FATHER'S NAME Isaac Webb

14. MOTHER'S MAIDEN NAME Watkins.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs Webb - Father | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis. — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intrauterine Anoxia? — DUE TO

(C) Prolonged labor - Polyhydramnios - Premature - Twins.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/5, 1942 *to* 11/5, 1942, *that I last saw the deceased alive on* 11/5, 19__, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Louis Jones M. D. | 1104 Druid Hill Ave | 11/6/42 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 10th/42 | Mt Auburn | Mt Wenana |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1942 | Counting for Williams, M.D. | Elroy O Wilson | 1000 Brantley Lane |

VS 150

160a

G79718

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79718
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY MADELINE MEYERS 340.3
2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Phoenix
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Sept. 9, 1949 | | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant | | Phoenix, Maryland | USA |

13. FATHER'S NAME: Albert Meyers
14. MOTHER'S MAIDEN NAME: Susanna Sheeler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Albert Meyers | Phoenix, Maryland |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Malnutrition

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | [ ] | 11-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-10-49 | Jessops Cemetery | Sparks, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | | LANDON M. BROOKS | Sparks, Maryland |

VS 151

8/a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79719

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79719

4201 Registered No.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | AUGUSTA | KNAUSS | 2. DATE OF DEATH: November 9, 1949 |

**3. PLACE OF DEATH:**
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3201 Washington Avenue

C. Length of stay in Baltimore: 25 Yrs. Mos. Days

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): 3201 Washington Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | May 10, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Retired | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Rithman | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Lewis Caler, 3201 Washington Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease

DUE TO with arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Chester J. Lubinski, M.D. M.D.<br>per: R S Fisher | ☒ / ☐ / ☒ | 11-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 12, 1949 | Druid Ridge Cem. | Balto Co |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | Charles P. Towell 944a 2727 Edmondson Ave. |

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-133186

G79720

G79720

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 023

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Allen Fenner

2. DATE OF DEATH: 11-4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 35yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 413 Heaver St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Married | June 1- 1898 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Albert Fenner

14. MOTHER'S MAIDEN NAME: Nettie Isablle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT'S NAME AND ADDRESS: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Lung Abscess | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Syphilitic Aortitis | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4 , 1949 *to* 11-4 , 1949, *that I last saw the deceased alive on* [illegible] 1949, *and that death occurred at* 4.30Pm *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-8-1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/10/49 | Mt Auburn Ct | Balto City |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949
REGISTRAR'S SIGNATURE: [signature] Baltimore, Md.
25. FUNERAL DIRECTOR: L. L. Brown & Son ADDRESS: 108 W. Montgomery St

VS 150

301

G79721

G79721

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN JOSEPH MILCHLING — MILCHLING

2. DATE OF DEATH 11/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 21-01

c. Length of stay in Baltimore Life — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 4719 Hazelwood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | April 7 1886 | 63 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motorman Balto. Transit

10B. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Balto.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Milchling

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO

17. INFORMANT Hospital Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO Cerebral Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/8, 1949, *to* 11/10, 1949, *that I last saw the deceased alive on* 11/9, 1949, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23A. SIGNATURE Theddeus Sowinski M. D.

23B. ADDRESS St. Joseph's Hosp.

23C. DATE SIGNED 11/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Nov. 12-49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) 4600 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Duggal Bros. ADDRESS 7110 Belair Rd.

VS 150

94a

Correct ICD if especially important; physicians: please write the causes of death clearly and legibly.

G79722

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79722

BIRTH NO. 31 Registered No.

1. NAME OF DECEASED (Type or Print): Leonora Samm

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland S. B. Gen. Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Brooklyn.
D. STREET ADDRESS (If rural, give location) 4503 Potee St. Highway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W | W | 12-1-1864 | 84. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home | Baltimore | |

13. FATHER'S NAME —

14. MOTHER'S MAIDEN NAME —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Fanny Samm | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL HEMORRHAGE
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) CEREBRAL SCLEROSIS
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
DIABETES MELLITUS

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 1949, *to* 11/8, 1949, *that I last saw the deceased alive on* 11/8, 1949, *and that death occurred at* — m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel P. Scalia M. D. | 1213 Light Street | 11/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 11-12-49 | Cedar Hill | Brooklyn, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | Thos. L. McCleary | 120 S. Fort Ave. |

Vs 150

61

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79723

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79723
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine Tanner

2. DATE OF DEATH: 11-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY
B 646 Hoffman St
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 17-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | W | | 63 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hill

14 MOTHER'S MAIDEN NAME: Martha Bell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Lucille Keys ADDRESS: 1053 Myrtha Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diffuse carcinomatosis
DUE TO
(B) Carcinoma of rectum
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* 11-8, 1949 *to* 11-9, 1949 *that I last saw the deceased alive on* 11-9, 1949 *and that death occurred at* 1 PM *m., from the causes and on the date stated above.*

23A SIGNATURE: J. Bredine M. D.

23B ADDRESS: University Hosp.

23C DATE SIGNED: 11-9-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 11 1949 | Mt Auburn Cem | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR: ISAIAH L. BROWN SON ADDRESS: 108 W Monty Mary St

VS 150

461

G79729 BALTIMORE CITY HEALTH DEPARTMENT 43 G79729

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) **William E. Delahunty** | 2. DATE OF DEATH **Nov. 8/49**

3. PLACE OF DEATH: A. **Baltimore City, Maryland** | B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **523 N. Longwood St.** | C. Length of stay in Baltimore **35yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE **Maryland** B. COUNTY | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore** 20-02 | D. STREET ADDRESS (If rural, give location) **523 N. Longwood St.**

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June 19, 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** | 10B. KIND OF BUSINESS OR INDUSTRY **Koppers Co.** | 11. BIRTHPLACE (State or foreign country) **Penn.** | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Michael Delahunty** | 14. MOTHER'S MAIDEN NAME **Mary Ann McCann**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. **214 05 3069** | 17. INFORMANT **Wm. E. Delahunty.** ADDRESS **523 N. Longwood St**

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Bronchopneumonia~~ — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

DUE TO

(B) chronic pulmonary oedema — 2 months

DUE TO

(C) Hypertensive cardiovascular Disease unKnown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1 1949 *to* Nov 8, 1949 *that I last saw the deceased alive on* Nov 7, 1949 *and that death occurred at* 3:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE **Nathan Rosnin** M. D. | 23B. ADDRESS **206 S. Gilmor St** | 23C. DATE SIGNED **11-9-49**

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City or County) (State) |
|---|---|---|---|
| Burial | Nov. 11/49 | New Cathedral | Balto. Md. 4300 Old Frederick Rd. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR: Harry N. Lintz | ADDRESS: 4101 Edmondson Ave.

Huntington Williams, M.D.

93D

G79725

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79725

1. NAME OF DECEASED (Type or Print): Schreiber, Emma
2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. of Baltimore
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 4313 Forest Park Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | Jan, 1 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore Maryland | |

13. FATHER'S NAME: William Fedder
14. MOTHER'S MAIDEN NAME: Rebecca Lewisohn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William Schreiber | 4313 Forest Park Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 48 hours |
| DUE TO (B) | Hypertension | Many years |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov. 9, 1949 | Increased intracranial pressure — encephalopathia | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 7 *to* Nov 9, 1949 *that I last saw the deceased alive on* Nov 9, 1949 *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harold Pescovitz, M.D. M.D. | Sinai Hospital Baltimore | Nov 9, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 11, 1949 | Arlington Mem Rogers Ave | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | Emmington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

G79726 BALTIMORE CITY HEALTH DEPARTMENT G79726

BIRTH NO. G79726 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Rosa Coleman

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1402 N. Fulton Avenue

c. Length of stay in Baltimore: 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-02
D. STREET ADDRESS (If rural, give location): 1402 N. Fulton Avenue

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: May 1, 1890
9. AGE (In years last birthday): 59 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boyton, Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Coleman
14. MOTHER'S MAIDEN NAME: Rose Andrews

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: John Coleman ADDRESS: 1402 N. Fulton Ave

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Insufficiency
DUE TO
(B)
DUE TO
(C) Arteriosclerosis (Generalized)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Chronic Nephritis

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1949, *to* Nov. 9, 1949 *that I last saw the deceased alive on* Nov 9, 1949, *and that death occurred at* 10:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Gilbert L. Caufield M. D.
23B. ADDRESS: 722 N. Fulton Ave
23C. DATE SIGNED: 11/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 11, 49
24C. NAME OF CEMETERY OR CREMATORY: Family Lot
24D. LOCATION (City, town, or county) (State): Wise [illegible] Carolina

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949
REGISTRAR'S SIGNATURE: Entitled to Williams M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS: North Ave.

VS 150

131a

Correct age if especially important. Physicians: please write the cause of death clearly and legibly.

G79727

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79727

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Maude Martinez

2. DATE OF DEATH: Nov 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1025 N. Eutaw Street

C. Length of stay in Baltimore: 23 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

D. STREET ADDRESS (If rural, give location): 1025 N. Eutaw Street

11-04

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: January 9, 1904

9. AGE (In years last birthday): 45 If under 1 year: Months Days If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Portsmouth, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Crawls

14. MOTHER'S MAIDEN NAME: Christina Alesta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Bermon Martinez ADDRESS: 608 E. 28th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Months 1 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 5, 1949 *to* Nov 9, 1949, *that I last saw the deceased alive on* Nov 5, 1949, *and that death occurred at* 2 0 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Emerson R. Julian M. D.

23B. ADDRESS: 1207 Madison Ave

23C. DATE SIGNED: 11/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE: Nov 14 1949

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Auburn

24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Funeral for Williams, M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home ADDRESS:

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

132

49-04573

BIRTH NO. G79728

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 8 12 G79728 Registered No.

1. NAME OF DECEASED (Type or Print): KATHLEEN SAUERHOFF SAUERHOFF N-80
2. DATE OF DEATH: November 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1309 Divers Court 25-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Child | Sept 26-1948 | 1 | 8 / 13 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ELMER B. SAUER HOFF
14. MOTHER'S MAIDEN NAME: MARY JAMES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ELLEN SAUERHOFF ADDRESS: 730 McHenry St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Comminuted crush fracture of skull
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1306 Divers Court 25/05
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): November 8, 1949 5.30 P.M.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Pedestrian struck by ice cream truck

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: NOV. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/12/49
24C. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
24D. LOCATION (City, town, or county) (State): FREDRICK RD BALTO MD

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949
REGISTRAR'S SIGNATURE: Hunter Williams M.D.
25. FUNERAL DIRECTOR: Charles W. Fackenthal ADDRESS: 703 McHenry St.

170C

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79729

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79729

Registered No. 177

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HOWARD JOSEPH HARPER

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION: US Marine Hospital (If not in hospital or institution, give street address or location) Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-06
D. STREET ADDRESS (If rural, give location): 3444 Keswick Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Wid. | 3/2/89 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard | Terminals Operator | Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Harper | Ida Wilhelm |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | 063-03-7107 | Records- US Marine Hospital | Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of prostate, metastatic to ribs, pelves, regional nodes | Approx. 1 yr. |
| DUE TO (B) | Cachexia | Unknown |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 20, 1949 *to* Nov. 8, 1949 *that I last saw the deceased alive on* Nov. 8 1949 *and that death occurred at* 6:20 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 12, 1949 | Baltimore National | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | [illegible] | Burgee Funeral Home | 3631 Falls Road |

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

51B

G79730 CERTIFICATE CORRECTED ✓11-16-49 G79730

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ~~ROSELLA~~ BERTHA 2 HARVEY 3 — 019.2

2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: 3 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 206 Detroit Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 11-26-1887 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Kitzmiller, Maryland | U.S.A. |

13. FATHER'S NAME: Alfred E. Harvey

14. MOTHER'S MAIDEN NAME: Rachel Walters

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 216-22-7280

17. INFORMANT: Edmund Harvey — ADDRESS: Baltimore, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Miliary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [✓], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: M. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: Nov. 10, 1949

24C. NAME OF CEMETERY OR CREMATORY: Thayerville

24D. LOCATION (City, town, or county) (State): Thayerville Oakland Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: William Cook Inc. ADDRESS: 1217 St. Paul St.

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79731

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 41 G79731

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas P. Murphy

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1631 Lamont Avenue

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 9/8/1898
9. AGE (In years last birthday): 51
If Under 1 Year: Months: 2 Days: 0
If Under 24 Hours: Hours: Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Huckster
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thomas P. Murphy
14. MOTHER'S MAIDEN NAME: ( ) McDonald
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: ?
17. INFORMANT ADDRESS: Mrs. Mary J. Murphy--1631 Lamont Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid and Intracerebral Hemorrhage
DUE TO
(B) Malignant Hypertension
DUE TO
Cardio-Vascular Renal
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8, 1949, to 11-8, 1949, *that I last saw the deceased alive on* 11-8, 1949, *and that death occurred at* 11:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. H. Snowden Jr. M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 11-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: II-I2-49
24C. NAME OF CEMETERY OR CREMATORY: Totuskey Cemetery,
24D. LOCATION (City, town, or county) (State): Haynesville, Virginia

DATE RECEIVED BY REGISTRAR: NOV 10 1949
REGISTRAR'S SIGNATURE: [illegible] M.D.
25. FUNERAL DIRECTOR: George J. Ruth, Inc.
ADDRESS: 1735 Harford Avenue

VS 150

937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79732

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79732 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET PHIPPS
2. DATE OF DEATH: 11/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 4304 Evans Chapel Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | Sept. 10, 1876 | 73 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Polk Billington | Emma Mace |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Clara Schmalz | 1301 Bolton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Cardiovascular Disease | 4 years |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection Injury *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| John R Davis, M.D. | | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 12, 1949 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G79733

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79733

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER JOSEPH WARREN

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: 50 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: NJ
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tuckerton
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | 9/9/11 | 38 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | CG | Pa. | USA |

13. FATHER'S NAME: John Warren

14. MOTHER'S MAIDEN NAME: Sophie Huen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW 2 | 136-24-8224 | Records- US Marine Hospital | Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1- Arteriosclerosis
(A) A- Coronary artery
DUE TO 1-Myocardial fibrosis
2- Cardiac hypertrophy & dilatation
3- Mural thrombus
DUE TO 4- Pulmonary oedema & inferotion
(C) B- Aorta

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Duration Unknown

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 20, 1949, *to* Nov. 9, 1949, *that I last saw the deceased alive on* Nov. 9, 1949, *and that death occurred at* 5:45 P m., *from the causes and on the date stated above.*

23A. Signature: William H. Stimson, Surgeon, M. D.

23B. ADDRESS: US Marine Hospital, Balto, Md.

23C. DATE SIGNED: 11/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 12/49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State): Tuckerton N.J.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Huntington Wilkerson, MD

25. FUNERAL DIRECTOR: John O. Mitchell Sons

ADDRESS: 1900 Eutaw Place

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

TO BE APPROVED BY MEDICAL EXAMINER

G79734 ✓ X 07 G79734

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) DAN RUFUS AXSON | 2. DATE OF DEATH Oct. 31, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.<br>c. Length of stay in Baltimore 31 days (Yrs. Mos. Days) | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Florida B. COUNTY<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fernandina<br>D. STREET ADDRESS (If rural, give location) 328 S. 9th St. |
| 5. SEX M | 6. COLOR OR RACE col |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single | 8. DATE OF BIRTH 3/7/05 |
| 9. AGE (In years last birthday) 44 | If Under 1 Year: Months Days; If Under 24 Hours: Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mate | 10B. KIND OF BUSINESS OR INDUSTRY Seafarer |
| 11. BIRTHPLACE (State or foreign country) Ga. | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME Rufus Axson | 14. MOTHER'S MAIDEN NAME Lula ? |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. 262-16-1868 |
| 17. INFORMANT ADDRESS Records- US Marine Hospital, Balto, Md. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia occurring during exploratory thoractomy for aneurysm of aortic arch — Interval between onset and death: Duration of aneurysm unknown

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

CERTIFICATION APPROVED BY

(C) George G. Merrill M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION 10/31/49 | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Hospital | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Marine Hospital |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-31-49 10:20 A.m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? Anesthetic death--Gas, oxygen, ether |

22. *I hereby certify that I attended the deceased from* Sept. 30, 1949 *to* Oct. 31, 1949, *that I last saw the deceased alive on* Oct. 31 1949 *and that death occurred at* 10:20A m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE John L. Wilson, Medical Director | 23B. ADDRESS US Marine Hospital, Balto, Md. | 23C. DATE SIGNED 11/8/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 11/10/49 | 24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Century |
| 24D. LOCATION (City, town, or county) (State) H. H. Co., Md | | |
| DATE RECEIVED BY LOCAL REGISTRAR NOV 10 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS Charles L. Law - 802 Madison Ave |

VS 150

20D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79735 ✓ G79735

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 291

1. NAME OF DECEASED (Type or Print): JOHN HOLLAND

2. DATE OF DEATH: Nov. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42 South Stockton Street

c. Length of stay in Baltimore: 30 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 42 South Stockton Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | May 3, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Rag Baler | Rag Company | West River A.A.Co.,Md. | USA |

13. FATHER'S NAME: DONALD HOLLAND

14. MOTHER'S MAIDEN NAME: ALICE ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 216-10-0802 | Andrew Holland | 1203 Mosher St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Broncho-pneumonia | Probably a few days |
| DUE TO (B) | Acute Upper Resp. Infec. + exposure | about 1 week |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis. Hypertensive Cardio-Vasc. dis. | Years. |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 7, 1949, *to* Nov. 7, 1949, *that I last saw the deceased alive on* Nov. 7, 1949, *and that death occurred at* 8 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Abram Goldman M. D. | 206 S. Gilmor St. | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Mount Calvary Cemetery | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | CHARLES R. LAW | 802 Madison Ave.-1 |

Vs 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

G79736

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

120.0

G79736

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) John Saganiewski ( Sagan ) (Segan)

2. DATE OF DEATH Nov. 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2404 Hudson Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 1-04

D. STREET ADDRESS (If rural, give location) 2404 Hudson Street

c. Length of stay in Baltimore: 50 Years (Yrs. Mos. Days)

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 26 1884

9. AGE (In years last birthday): 65 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper on Truck

10B. KIND OF BUSINESS OR INDUSTRY: Sours Cooperege

11. BIRTHPLACE (State or foreign country): Poland

12. CITIZEN OF WHAT COUNTRY? Poland

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-10-0964

17. INFORMANT: Mrs. Tekla Saganiewski ADDRESS 2404 Hudson St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Arteriosclerotic Heart Disease — 2

DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C) Influenza — 3 days

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 9 1949 to Nov 8 1949 that I last saw the deceased alive on Nov 7 1949 and that death occurred at 3:30 p.m. from the causes and on the date stated above.

23A. SIGNATURE Francis J. Januszewski M.D.

23B. ADDRESS 540 N. Fremont

23C. DATE SIGNED 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 11 49

24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cem.

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: John M. Weber ADDRESS: 401 S. Chester Street

VS 150

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ES-128948 G79737 G79737

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420.0

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) James Bailey

2. DATE OF DEATH 11-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals

c. Length of stay in Baltimore 42 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2915 Hudson Street 1-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | March 24, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Colorado | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Richard Bailey | Mary Welser |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | RECORDS*BALTO. CITY HOSPITALS EASTERN AVE 4940 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5-12, 1949, *to* 11-8, 1949 *that I last saw the deceased alive on* 11-8, 1949, *and that death occurred at* 12:40 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Bozan M. D. | 4940 Eastern Avenue | 11-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/11/49 | Oak Lawn Mem | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams, M.D. | Geo L. Bayer Jr | 512 Hollins St. |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79738 ✓ G79738

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 43

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Magdalena M. Eckert

2. DATE OF DEATH Nov. 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 534 S. Bentalou St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore Life 59 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-05
D. STREET ADDRESS (If rural, give location) 534 S. Bentalou st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Sept. 16-1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at Home | Baltimore Md | U. S. |

13. FATHER'S NAME John D. Kappauff

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mr. John J. Eckert | 534 S Bentalou St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypertensive | 1 yr. |
| DUE TO (B) | Hypertensive cardio vascular disease | 2 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | None | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/1, 1949, *to* 11/8, 1949, *that I last saw the deceased alive on* 11/6, 1949, *and that death occurred at* 8 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lawrence Weller M.D. M. D. | 2030 Wilkens Ave. | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-12-49 | Western Cem. | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | [illegible], M.D. | Geo E Beyer Jr | 1512 Hollins st |

VS 150

63B

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79739 BALTIMORE CITY HEALTH DEPARTMENT G79739

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mary Lavery

2. DATE OF DEATH: Nov. 9 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 618 E. Biddle St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 618 E. Biddle St 12-01

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore | U. S. |

13. FATHER'S NAME: Michael Roche

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Miss Kerrigan 618 E. Biddle St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Endo-Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(B) Generalized arterio sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs Plus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1939, 19__, *to* Nov 9/49, 19__, *that I last saw the deceased alive on* Nov 8, 19 49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A Fraghy M. D. | 10 E Biddle St | Nov 9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 11. 1949 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | Rita Riedefeld 900 E. Biddle St |

92)

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79740 ✓ G79740

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Margaretta Marie Schroeder
2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2106 Wilhelm St.
c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2106 Wilhelm St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 2, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Germany | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Reicherter | Frederica Reicherter |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 214-03-1289 | Frederick W. Schroeder | 2106 Wilhelm St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic cardiovascular disease | 6 mos |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST (B) | none | |
| DUE TO | | |
| (C) | Cerebral thrombosis | 6 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 6/12, 19 49 *to* 11/9, 19 49, *that I last saw the deceased alive on* 11/9, 19 49 *and that death occurred at* 2:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Miller MD M.D. | 1030 Wilkens Ave | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 12, 1949 | Western | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | Geo. L. Schwab | 2101 Frederick Ave |

VS 150

931

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79741

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

5 9 ✓ G79741

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Catherine Carns Carey

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2931 Presstman St.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2931 Presstman St., 16 07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Nov. 4, 1857
9. AGE (In years last birthday): 92 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Alexander G.W.Carns
14. MOTHER'S MAIDEN NAME: Emma Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mrs. Helen C. Crook ADDRESS: 1600 Ellamont St.,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronco Pneumonia — Interval between onset and death: 3d. 8d.
DUE TO
ANTECEDENT CAUSES
(B) arterio sclerosis & Hypertension — 18 mo.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) Chronic Interstitial Nephritis — 18 mo.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Beginning Gangrene Lt. Leg - due to Thrombus — 3d

19A. DATE OF OPERATION: no
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 2, 19 49, *to* Nov. 9, 19 49, *that I last saw the deceased alive on* Nov 8, 19 49, *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: J F A Stevens, M. D.
23B. ADDRESS: 2878 Hartford Rd
23C. DATE SIGNED: Nov. 9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-11-1949
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949
REGISTRAR'S SIGNATURE: Cunningham Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

131a

G79742

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79742

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine Feela

2. DATE OF DEATH: Nov 8- 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1538 E Clement St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1538 E. Clement St.

c. Length of stay in Baltimore: 15yr Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1538 E Clement St 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | July 10 1861 | 88 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bohemia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph Cvack
14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Lang ADDRESS: 1538 E Clement St

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Broncho Pneumonia | 3 day |
| DUE TO (B) | Arteria Sclerosis + H & Dilatation | 1 yr |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Mitral Regurgitation + Chr Interstitial Nephritis | 1 yr |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION: Non
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* Nov 8, 1949, *that I last saw the deceased alive on* Nov 7, 1949, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Geo. F A Stevens M. D.
23B. ADDRESS: 2878 Harford Av
23C. DATE SIGNED: 11-9 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 11/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 10 1949
REGISTRAR'S SIGNATURE: Cunningham Williams, M.D.
25. FUNERAL DIRECTOR: Frank Cvach ADDRESS: 909 N. Chester St, 1310

VS 150

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79743

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 17

G79743 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Ridgely

2. DATE OF DEATH November 10, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY A.A. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sudlersville
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 2-26-09 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Oden Coppage | Lula Legore |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-26 1949 *to* 11-10 1949 *that I last saw the deceased alive on* 11-16 1949, *and that death occurred at* 8:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Angell M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 13-49 | Church Hill | Church Hill Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 15 1949 | Washington Millington M.D. | Edgar L Lane Church Hill Md |

48a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79744 BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 900 G79744 Registered No.

1. NAME OF DECEASED (Type or Print): Douglas McCLARY (Emmg) — N-803.7
2. DATE OF DEATH: Nov. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1808 E. Lombard St. 2-07

5. SEX: M
6. COLOR OR RACE: W
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ ~~DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 3/30/1894
9. AGE (In years last birthday): 55 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during greater part of working life, even if retired): Seaman
10B. KIND OF BUSINESS OR INDUSTRY: Maritime
11. BIRTHPLACE (State or foreign country): Richmond Va
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John T. McClary
14. MOTHER'S MAIDEN NAME: Annie E. McClary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Ruth Chesney — ADDRESS: 4222 Woodlea Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured skull.
DUE TO
(B) Intracranial hemorrhage. Contusion of brain.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1808 E. Lombard St. 2/2
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 3, 1949 2 P
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR?: Fell down steps

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11/10/49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 11/12/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 151

186a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79745

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79745

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY M. GIBBONS

2. DATE OF DEATH: 11-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital of Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-09
D. STREET ADDRESS (If rural, give location): 1507 Lockwood Rd

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: Nov 20th 1878
9. AGE (In years last birthday): 70
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph C. Krug
14. MOTHER'S MAIDEN NAME: Annetta Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-09-1123B
17. INFORMANT: Gretchen Caldwell 1507 Lockwood Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion - Myocardial Infarction
DUE TO
(B) Hypertensive Arteriosclerotic Cardiovascular dis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [V] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8, 1949 *to* 11-10, 1949 *that I last saw the deceased alive on* 11-10-, 1949, *and that death occurred at* 4:20 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Howard H. Michael M.D.
23B. ADDRESS: Sinai Hospital Balto.
23C. DATE SIGNED: 11-10-49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial
24B. DATE: 11/12/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Cathedral
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949
REGISTRAR'S SIGNATURE: Winston for Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. G79746

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79746

1. NAME OF DECEASED (Type or Print): RUFUS R. SHORT — 57 Yr. 1
2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE GENERAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Co.
D. STREET ADDRESS (If rural, give location): Severn Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | April 11th 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | Retired Ft Meade | Md. | |

13. FATHER'S NAME: Lodge L. Short
14. MOTHER'S MAIDEN NAME: Acsha A. Hood

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Margaret Brown | Severn Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) IRREVERSABLE SHOCK | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) CAUSE UNDETERMINED | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | ARTERIOSCLEROSIS GENERALIZED | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/9/49 | DIVERTICULUM OF ILEUM | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/6, 1949, to 11/9, 1949, *that I last saw the deceased alive on* 11/9, 1949, *and that death occurred at* 7:10 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William B Cooper M. D. | South Balto General Hosp. | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Funeral for William M. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

123

Please write clearly and legibly. Physicians: please write the cause of death clearly and correct age is especially important.

G79747

BIRTH NO. G79747

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 2747

1. NAME OF DECEASED (Type or Print): Adaline E. Mitchell

2. DATE OF DEATH: 11-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. Gen'l Hosp
C. Length of stay in Baltimore: Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: V
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 1329 E. North Ave 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | Col | Married | Nov 27th 1876. | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Balto. Md. | |

13. FATHER'S NAME: Edward R. Welch

14. MOTHER'S MAIDEN NAME: Laura D. Earhart

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Harry N. Mitchell | 1329 E. North Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infa | 5 mos |
| DUE TO (B) | [illegible] | [illegible] |
| DUE TO (C) | [illegible] | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | [illegible] | [illegible] |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible] *to* [illegible], 19[illegible], *that I last saw the deceased alive on* [illegible], 19[illegible], *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | [illegible] | [illegible] |

| 24A. BURIAL, CREMATION, REMOVAL, OTHER (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/14/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | [illegible] for Alliance, Inc. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

93D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79748

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

4 no. 1

G79748 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis F. Doberer Jr.

2. DATE OF DEATH: 10 Nov. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2830 W. Lanvale St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2830 W. Lanvale st 16-06

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, ~~MARRIED~~, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10/14/1879
9. AGE (In years last birthday): 70 — If under 1 Year: Months / Days — If under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Clerk
10B. KIND OF BUSINESS OR INDUSTRY: Wholesale Lumber Business
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Louis F. Doberer Sr.
14. MOTHER'S MAIDEN NAME: Anna K. Dietz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Arthur Doberer — ADDRESS: 5813 Royal Oak Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Ramme, Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 10 Nov. 1949

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 11/12/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~: Lorraine
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul St.

VS 151

94a ✓

G79749

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79749

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel Levin

2. DATE OF DEATH: 11-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore and [illegible]
D. STREET ADDRESS (If rural, give location): 3418 Reisterstown Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | married | April 14, 1894 | 55 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Simon Levin

14. MOTHER'S MAIDEN NAME: Anna Segal

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Anna Levin ADDRESS 3618 Reisterstown Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic myeloid leukemia
DUE TO
(B) Bronchopneumonia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 19[illegible] *to* 11-10, 19[illegible] *that I last saw the deceased alive on* 11-10-, 19 49 *and that death occurred at* 7:05 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: H C Kaiser M. D.
23B. ADDRESS: Univ Hospital
23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 11, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rosedale Cem
24D. LOCATION (City, town, or county): Baltimore (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: 11-11-49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North Ave

VS 150

74a

Please write clearly with ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

AB-133288 G79750 **CERTIFICATE CORRECTED** 6-1-51 G79750

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

4 16 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eli ~~Postin~~ E. (~~Postin~~?) Pasten

2. DATE OF DEATH: 11-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 16yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural) Essex
D. STREET ADDRESS (If rural, give location): 111 Alcock Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Married | April 12- 1896 | 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Europe

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Eli ~~Postin~~ Pasten

14. MOTHER'S MAIDEN NAME: Susan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Baltimore City Hospitals records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rheumatic Heart Disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8- , 1949 *to* 11-9- , 1949, *that I last saw the deceased alive on* 11-9- , 1949, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. C. Logan M. D.

23B. ADDRESS: Baltimore City Hospitals

23C. DATE SIGNED: 11-10-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 12 49

24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart

24D. LOCATION (City, town, or county) (State): Balto.. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John J. Connelly

ADDRESS: 418 Eastern Ave Balto. 21, Md

VS 150

95 B

Please write clearly and legibly. Physicians: please write the causes of death clearly and correct age is especially important.

G79751 BALTIMORE CITY HEALTH DEPARTMENT EP16.D G79751

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH B. MAGAHA
2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEst Baltimore General Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1212 Guilford Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept.17, 1924 | 25 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | Baltimore City F.D. | Baltimore | |

13. FATHER'S NAME: Harry L. Magaha
14. MOTHER'S MAIDEN NAME: Margaret J. Rehmert

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | W. W. 2 | | Catherine M. Magaha | 1212 Guilford Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed skull

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Fracture of right tibia and fibula
Fracture of middle third, right femur
Fracture of sternum

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public | Park Heights Avenue and Rogers Avenue |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-9-49 3:15 P m. | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | Collision between hook and ladder and hose truck of Fire Department |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| R K Fisher M.D. | | 11-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov.12, 1949 | New Cathedral | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Carrington Williams M.D. | Frederick A. Cole | 1913 W. Baltimore St. |

VS 151

170c

Please write legibly. Every item of information should be carefully supplied, with correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79752

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79752

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA GLAZER

2. DATE OF DEATH: 11/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3038 Druid Parkway -
C. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 15 - 05
D. STREET ADDRESS (If rural, give location): 3038 Druid Parkway.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None. | | Russia | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harry Caplan | Mary |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Robert Glazer | 3116 Mondawmin |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Hypertension Nephritis
DUE TO
(C) Chronic Myocardiitis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1/10/50 19[44] *to* 11/10, 1949, *that I last saw the deceased alive on* 11/10, 1949 *and that death occurred at* 6-6, *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Frankel M. D. | 1212 W. Lee St | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 11-11-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

937

*Please write plainly in ink. Physician: please write the cause of death clearly and legibly. Information should be complete and correct as far as known. Date of death is especially important.*

G797553 G797553

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lena Cohen

2. DATE OF DEATH: 11-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 4007 Fairview Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 74
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Israel
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marian Cohen ADDRESS: 4007 Fairview Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CVA + Bronchopneumonia

DUE TO

(B) HASCVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-6 19 49 *to* 11-10, 19 49, *that I last saw the deceased alive on* 11-10, 19 49 *and that death occurred at* 4 45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Kot M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-11-49
24C. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh
24D. LOCATION (City, town, or county): Balto (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

937

G79754 BALTIMORE CITY HEALTH DEPARTMENT G79754

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Rev. William Gardner Minnick
2. DATE OF DEATH: 11-9-49
3. PLACE OF DEATH: A. Baltimore City, Maryland 2027 St. Paul St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 35 yrs. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2027 St. Paul St. 12-04
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 20, 1866
9. AGE (In years last birthday): 83 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Middletown, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ezra Minnick
14. MOTHER'S MAIDEN NAME: Henrietta Gardner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT ADDRESS: Mrs. Elsie Shepter, Towson, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis DUE TO

(B) senility DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 3, 1949 *to* Nov 9, 1949, *that I last saw the deceased alive on* Nov 3, 1949 *and that death occurred at* 2 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE W. H. Pearce M.D.
23B. ADDRESS 2105 N. Charles St.
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-12-49
24C. NAME OF CEMETERY OR CREMATORY: Zion Cemetery
24D. LOCATION (City, town, or county) (State): Middletown, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, MD
25. FUNERAL DIRECTOR ADDRESS: C. Vernon Lemmon, 4611 Pk. Hghts.

VS 150

94a

G79755 G79755

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 816 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES PAFF N-804.1
2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4204 Reisterstown Road 15-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 27, 1892 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | Fire Department | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Adam Paff
14. MOTHER'S MAIDEN NAME: Elizabeth Keil

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War #1 | | Anna Paff | 4204 Reisterstown Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull
DUE TO with multiple fractures of bones of extremities and ribs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public | Park Heights & Rogers Avenue 27/18 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-9-49 3:15 P m. | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | Collision between hook and ladder and hose truck of Fire Department |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. B. Fisher M.D. | | 11-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-12-49 | Holy Redeemer | Baltimore City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | C. VERNON LEMMON | 4611 Park Heights Ave. |

170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79756 ✓ G79756

BIRTH NO. G79756

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Coady Lurz

2. DATE OF DEATH: 11/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3500 Spaulding Ave.
c. Length of stay in Baltimore: About 75 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY: ----- ---------
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3500 Spaulding Ave. 27-15

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday / If Under 1 Year: Months Days / If Under 24 Hours: Hours Min. |
|---|---|---|---|---|
| Female | White | Widowed | Unknown | About 75 -- - -- -- |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | ---------- | Baltimore, Md. | -------- |

13. FATHER'S NAME: Michael Coady

14. MOTHER'S MAIDEN NAME: Mary Lyons

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ---------- | --------- | Mrs. Mary Lurz O'Toole | Wil. Del. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis with Dilatation — INTERVAL BETWEEN ONSET AND DEATH: Many Years

DUE TO

ANTECEDENT CAUSES

(B) 7 days.

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Chronic General Arteriosclerosis — many years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT — age -

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November 3, 1949 *to* Nov 10, 1949, *that I last saw the deceased alive on* Nov 7, 1949, *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. W. Keown MD M. D. | 1738 Linden Ave | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | H. H. Meare & Son | 805 N. Calvert St. |

VS 150

92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G797.57

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G797.57 443 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Thomas Johnson

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1731 S. Hanover St. 23-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months, Days | If Under 24 Hours Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 29, 1903 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard | G. L. Martin Co. | Portland, Maine | U.S.A. |

13. FATHER'S NAME: Johnson

14. MOTHER'S MAIDEN NAME: Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 216-16-9988

17. INFORMANT: Rose Marie Johnson ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Heart Disease

~~DUE TO~~ with

(B) Myocardial insufficiency

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R. S. Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 10, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Holy Cross | Brooklyn, A.A. Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949

REGISTRAR'S SIGNATURE: per Hattie Lee Williams, M.D.

25. FUNERAL DIRECTOR: A. Howard Evans Son ADDRESS: 1400 S. Chas. St. Balto. 30, Md.

93D

G79758 G79758

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Emma A. Kaber

2. DATE OF DEATH Nov. 7-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 133 S. Caloverton Road

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 133 S. Caloverton Road 20-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 10/21/1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore City | U.S.A. |

13. FATHER'S NAME Henry Holdsmacher

14. MOTHER'S MAIDEN NAME Emma Schmidt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Louis M. Kaber | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 10 min.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Essential — 6 year

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 21 –, 1949, *to* Nov. 7 –, 1949, *that I last saw the deceased alive on* Nov 7-, 1949, *and that death occurred at* 7-20 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. McCollum M. D. | 3321 Frederick Ave | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 11-49 | Loudon Park | Baltimore - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | H. B. Wippert & Son | 1300 Eutaw Pl 17 |

83a

AB-128637 G79759

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79759

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Emory (Emron?) Miller (EMILE MILLER)

2. DATE OF DEATH: 11-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 406 Burns Ct. 19-04

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 10- 18(66) March 10-1866
9. AGE (In years last birthday): (83)--83
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Emory Miller
14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT'S NAME AND ADDRESS: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized arteriosclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 10-11-1949
19B. MAJOR FINDINGS OF OPERATION: Intestinal Obstruction
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-30- , 19 49 *to* 11-9- , 19 49 *that I last saw the deceased alive on* 11-9- , 19 49 *and that death occurred at* 9.30P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: Nov. 12-49
24C NAME OF CEMETERY OR CREMATORY: London Park.
24D LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.
25 FUNERAL DIRECTOR: C. T. Gilbert & Son
ADDRESS: 1200 Eutaw Pl. 17

VS 150

1220

G7976O

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G7976O

BIRTH NO.

Registered No.

E816.0

N-804.1

1. NAME OF DECEASED (Type or Print): JAMES W. HAYNIE

2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5612 Stonington Avenue 28-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 9, 1923 | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | Fire Dept. Balto.City | Baltimore, Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Randolph R. Haynie | Olive Leach |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War No. 2 | no | Mr. Randolph R. Haynie | 5612 Stonington Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushing injuries of chest

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

DUE TO

(C) Fracture of right humerus
Fracture of left femur
Fracture of pelvis, left

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public | Park Heights Avenue & Rogers Avenue |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-9-49 3:15 P m | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | Collision between hook and ladder and hose truck of Fire Department |

27/8

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fraske M.D | | 11-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-14-49 | Baltimore National Cem | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | WILLIAM J. TICKNER & SONS | Balto., Md. |

NOV 51

170c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79701 ✓ X G79701

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 137082

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. HARRY E PHILLIPS
2. DATE OF DEATH: 11-10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: 37 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Relay
D. STREET ADDRESS (If rural, give location): 5118 Rolling Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | white | widowed | 11-18-1876 | 72 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk (retired) | Railroad | Baltimore, Md. | |

13. FATHER'S NAME: HARRY PHILLIPS
14. MOTHER'S MAIDEN NAME: DELL C. MILLER

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | | | Mr. Charles E. Phillips | 5118 Rolling Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Sigmoid Colon
DUE TO
(B) c Post-Operative Cardiac Failure & atelectasis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/7/49 | Carcinoma Sigmoid Colon | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/ 5 *19*49 *to* 11/10 *, 19*49 *that I last saw the deceased alive on* 11/10/49 *, 19* ___ *, and that death occurred at* 7 P. M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank T. Dreyer M.D. | St. Agnes Hosp | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

46E

G797:2 BALTIMORE CITY HEALTH DEPARTMENT G797:2

# CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Charles J. Phillips
2. DATE OF DEATH Nov. 10, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital
6. Length of stay in Baltimore 74 years Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location) 300 E. 30th St
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Apr 10, 1875
9. AGE (In years last birthday) 74 If under 1 Year: Months Days; If under 24 hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool & Welding
10B. KIND OF BUSINESS OR INDUSTRY Tool & Welding
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Phillips
14. MOTHER'S MAIDEN NAME Sally Adams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO none
17. INFORMANT Mrs. Beatrice A. Phillips ADDRESS 300 E. 30th

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Cerebro vascular Accident

DUE TO

(C) Arterio Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 4 1949 *to* Nov 10 1949, *that I last saw the deceased alive on* Nov 10, 1949, *and that death occurred at* 2 10 Am., *from the causes and on the date stated above.*

23A. SIGNATURE Lee Woodall Lowe, Jr. M.D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11/12/49
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.
24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 14 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

VS 150

83a

G797c3 BALTIMORE CITY HEALTH DEPARTMENT G797c3

# CERTIFICATE OF DEATH

Registered No. 4 no. 1

BIRTH NO

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): JOSEPH C. HOWARD, Sr.

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4301 Penhurst Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4301 Penhurst Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | divorced | Nov. 15, 1867 | 81 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Owner (rt'd) | Jewelry | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph C. Howard | Elizabeth Mullen |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Elizabeth Yearley | 4301 Penhurst Av. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Probably months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| ✓ | ✓ | ✓ |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| ✓ m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | ✓ |

22. *I hereby certify that I attended the deceased from* about Oct 26 19__, *that I last saw the deceased alive on* 11/6, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry Carroll M. D. | 3902 Gramercy | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Mt. Olivet Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Chas. Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

Vs 1949

942

G797c4

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G797c4

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): WILMER GARRISON UMSTAD

2. DATE OF DEATH: Nov. 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1632 Ashburton St. 15-C 6

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10/18/88
9. AGE (In years last birthday): 61 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Field Employee
10B. KIND OF BUSINESS OR INDUSTRY: Balto, Md. US Marine Hospital

11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nace Umstad
14. MOTHER'S MAIDEN NAME: Bertha Moller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT ADDRESS: Records- US Marine Hospital, Balto, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage and edema, retro-peritoneal, pelvic, postoperative — Interval between onset and death: Less than 24 hrs.

DUE TO

(B) Hypertension — Unknown

DUE TO

(C) Pulmonary congestion and edema — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11-8-49
19B. MAJOR FINDINGS OF OPERATION: Enlarged prostate
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 31, 1949, *to* Nov. 8, 1949, *that I last saw the deceased alive on* Nov. 8 1949, *and that death occurred at* 5:45 Pm., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson, Medical Director M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 11-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/12/49
24C. NAME OF CEMETERY OR CREMATORY: Western Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Evelyn Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

1370

G797c5 G797c5

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

193 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ernesto Suarez

2. DATE OF DEATH: Nov. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Colombia So. America
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Barranquilla
D. STREET ADDRESS (If rural, give location): 5084 66th st. 7-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | | 3-8-1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Dentist | | So. America | So. America |

13. FATHER'S NAME: Cristobal Suarez

14. MOTHER'S MAIDEN NAME: Alicia Redongo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — JOHNS HOPKINS HOSPITAL — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | PULMONARY EDEMA | 24 hrs. |
| DUE TO (B) | malignant | (over) |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | BRAIN TUMOR | 5 mos. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 4 Nov 49 | INFILTRATING TUMOR Rt PARIETAL | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/27, 1949 *to* 11/10, 1949, *that I last saw the deceased alive on* 11/10, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert G. Foley M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/11/49 | | Barranquilla, Colombia, S.A. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | Earl B. Proctor | 403-6-25 = St. 541 Baltimore 18. Md. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79706

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. G79706

BIRTH NO.

1. NAME OF DECEASED (Type or Print): NAOMI M. TOPPIN

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 806 DRUID Hill AVE.
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 17-01
D. STREET ADDRESS (If rural, give location): 806 DRUID Hill AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | WIDOWED | 4-2-1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| UNEMPLOYED | | BALTO. MD. | U. S. A. |

13. FATHER'S NAME: NICKOLAS BROWN

14. MOTHER'S MAIDEN NAME: ANNIE R. STEWART

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE. (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 7-13, 19[illegible] *to* 11-8, 1949 *that I last saw the deceased alive on* 11-2, 1949 *and that death occurred at* [illegible] *m. from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Atwell Jones M. D. | 5-5-4 Dolphin St | 11-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 10-14-49 | Mt. Auburn | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | W. Halstead - 918 Eutaw St |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physician: please write the cause of death clearly and legibly.

937

679767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679767

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) VALERIA (JINGLESKI) DZIENGELEWSKI

2. DATE OF DEATH Nov-11-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 308 S. Elwino Ste

c. Length of stay in Baltimore 13 mo. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 308 S. Elwino Ste 26 05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | [redacted].10-1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at Home | Penna | |

13. FATHER'S NAME George Zaboski

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mr. Zygmunt Dziengelewski |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocarditis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/10, 1949, *to* 11/11, 1949, *that I last saw the deceased alive on* 11/10, 1949, *and that death occurred at* 2:17 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Gilbert | 606 Cathedral Av | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Removal | 11-11-49 | St. Mary's Cem. | Hanlocke Penna. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | John B. Connelly | 418 Eastern Ave. |

93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physician: please write the causes of death clearly and legibly.

G79768

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 443 G79768

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John (Johnnie) Draper — 16-04

2. DATE OF DEATH: 11/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1117 N Appleton St

C. Length of stay in Baltimore: 2½ (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1117 North Appleton St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 1117 N. Appleton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 12/11/1887 | 61 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Va | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm Draper | Mildred Frazier |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Wm Draper | 1117 N Appleton St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Heart — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hemiplegia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-15- 1949 *to* 11-10- 1949 *that I last saw the deceased alive on* 11-9- 1949 *and that death occurred at* 5:00 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George C. Page M. D. | 1516 N. Mount St. (17) | 11-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/13/49 | Zion Cemetery | King & Queen, Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, MD | Joseph L Russo | 6200 McClellan |

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G79769

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79769 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles A. Bateman JR.

2. DATE OF DEATH: 11/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 7 S. Fremont 4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | single | Nov 14, 1949 | | 2 28 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles A. Bateman, SR.
14. MOTHER'S MAIDEN NAME: June Agro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Mr Charles A Bateman ADDRESS 7 S. Fremont

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia Lobar, Lower right | 3 days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Marasmus | 12 months |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/10, 19 49, *to* 11/11, 19 49, *that I last saw the deceased alive on* 11/11, 19 49, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. Richard Franel M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 11/11/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Loudon Park Cem | 3801 Frederick Ave |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan
ADDRESS: 908 Hollins St.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79770 BALTIMORE CITY HEALTH DEPARTMENT 63 G79770
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) LOUIS E. GITTINGS
2. DATE OF DEATH November 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1501 De Soto Road
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1501 DeSoto Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | Nov. 18, 1878 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Y.M.C.A. | St. Mary's Co. Penna. | |

13. FATHER'S NAME: Edward Gittings
14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Mrs. Louise Gittings | 1501 De Soto Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma, lung | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Nov. 10, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 12, 1949 | Moreland Memorial Park | Parkville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 11 1949 | Huntington Williams, M.D. | Ullrich Funeral Home | 2008 Orleans St., |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47D

G79771 CERTIFICATE CORRECTED 11-16-49 ✓ G79771

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44 3

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE W. ALLEN

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Earl Court Apts. St. Paul & Preston Sts.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-1
D. STREET ADDRESS (If rural, give location): Earl Court Apts., St. Paul & Preston Sts.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | Mar. 18, 1897 | 52 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Electric Co. | Honeye, Pa. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W. #2 | 341-10-1699 | Mrs. Irma T. Allen | Earl Court Apts. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 6 hr

DUE TO

(B) Auricular Fibrillation — 1

DUE TO

(C) Hypertensive Cardiovascular Disease — 5 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 7, 19 49, *to* Nov 9, 19 49, *that I last saw the deceased alive on* Nov 9 19 49, *and that death occurred at* 6 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2407 Eutaw Place | Nov 11 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/12/49 | Balto. National Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | [signature] Registrar Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79772 BALTIMORE CITY HEALTH DEPARTMENT G79772

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Nellie Plitt
2. DATE OF DEATH: 11/10/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp. — C. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland — B. COUNTY Baltimore City — C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 16-05 — D. STREET ADDRESS (If rural, give location): 2523 W. Lafayette Ave #16
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 2/27/1871 — AGE (In years last birthday): 78 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
9B. KIND OF BUSINESS OR INDUSTRY: Home
10. BIRTHPLACE (State or foreign country): Maryland
11. CITIZEN OF WHAT COUNTRY?
12. FATHER'S NAME: Rev. Frederick P. Hennighausen
13. MOTHER'S MAIDEN NAME: Sarah Eva Lepley
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)
15. SOCIAL SECURITY NO: no
16. INFORMANT: Mr. Walter E. Plitt — ADDRESS: 2523 W. Lanvale St.

## MEDICAL CERTIFICATION

17. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction
DUE TO
(B) Hypertensive Arteriosclerotic cardio-vascular disease
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Pneumonia

INTERVAL BETWEEN ONSET AND DEATH:

18A. DATE OF OPERATION
18B. MAJOR FINDINGS OF OPERATION
19. AUTOPSY? YES [X] NO [ ]
20A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
20B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
20D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
20E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20F. HOW DID INJURY OCCUR?

21. I hereby certify that I attended the deceased from 11/2, 1949, to 11/10, 1949, that I last saw the deceased alive on 11/10, 1949, and that death occurred at 8:30 P. m., from the causes and on the date stated above.

22A. SIGNATURE: Orlyn H. Wood, M. D. — 22B. ADDRESS: West Baltimore General Hosp — 22C. DATE SIGNED: 11/10/49

23A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23B. DATE: 11/14/49 — 23C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem. — 23D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79773

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

581.0

G79773 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): LUTHER C. FOLLMER

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH: A Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

C. Length of stay in Baltimore: 2 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4707 Norwood Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 25, 1902 | 47 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mfgrs. Agent | Radio | Balto., Md. | |

13. FATHER'S NAME: Henry Follmer

14. MOTHER'S MAIDEN NAME: Anna Hohman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. M. Beatrice Follmer | 4707 Norwood |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Cirrhosis of Liver

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/23/49 | Cirrhosis liver - Post oper. adhesions | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/15/, 1949 *to* 11/11/, 1949, *that I last saw the deceased alive on* 11/11/, 1949, *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. Shohler M.D. | Bon Secours Hosp. | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/14/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Washington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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G79774

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79774

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Victor L. Staub

2. DATE OF DEATH Nov. 9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Dys.)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2742 Mosher St. 16-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | W. | Widower | Nov. 27/84 | 64 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | City of Baltimore | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles M. Staub | Louise F.********** |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Victor L. Staub, Jr., | 2742 Mosher St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: immediate

DUE TO

(B) Hypertensive cardio vascular disease. — 5/7/47

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 7, 1947 *to* Nov. 9, 1949 *that I last saw the deceased alive on* 11/6/1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Deibel M.D. | 1226 Hanover St. | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 12/49 | Most Holy Redeemer | 4430 Belair Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 1 1949 | Huntington Williams, M.D. | Harry A. Diffenderffer | 601 Edmondson Ave. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the cause of death clearly and legibly.

930

BIRTH NO. G79775

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54.4 G79775 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Joanna Jablon

2. DATE OF DEATH: November 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): alexandria
D. STREET ADDRESS (If rural, give location): 706 Tennessee Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Child | 8-6-1949 | | 3 / 4 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | 19ist. of Col. | |

13. FATHER'S NAME: Seymour Jablon

14. MOTHER'S MAIDEN NAME: Thelma Berger

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT - ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Anomalous Coronary Artery

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-8, 1949, *to* 11-10, 1949 *that I last saw the deceased alive on* 11-10, 1949, *and that death occurred at* 6 20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leone Baxter Lis M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. (BURIAL) CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov - 14 49 | George Washington Cem. | Hyattsville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | | W B Dennenberg & Son | 3501 - Otis St N W |

VS 150

Huntington Williamsport, Md

157E

G797776

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G797776

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Saul M. Sturman — 704.1

2. DATE OF DEATH: NOV 11 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 4 Mo. 0 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: D.C.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 4701 Connecticut Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 10-28-1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchandise Manager | Lansburgh Dept. | N. Y. | |

13. FATHER'S NAME: Henry Sturman

14. MOTHER'S MAIDEN NAME: Matilda Jacoby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pemphigus | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7- 1949 *to* 11-11- 1949, *that I last saw the deceased alive on* 11-11 1949 *and that death occurred at* 5:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert B. Payne M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 11 Nov 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/13/49 | Salm Fields Cem. | Brooklyn, N.Y. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR — ADDRESS: HENRY SANDER & SONS, INC.

VS 150

153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79777 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79777 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Mr. J. HENRY THEIS
2. DATE OF DEATH: 11-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL.
c. Length of stay in Baltimore: LIFE. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: BALTIMORE City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE - 14
D. STREET ADDRESS (If rural, give location): 9512 HARFORD ROAD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single. | July 17, 1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE Retired ~~NONE~~. | Barber | MARYLAND. | USA |

13. FATHER'S NAME: FREDERICK THEISS
14. MOTHER'S MAIDEN NAME: MARIE FRESE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT'S ADDRESS |
|---|---|---|---|
| UNKNOWN | No | none | Mr. Frederick Manser 9512 Harford Rd. - 14 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HYPERNEPHROMA — DUE TO
(B) — DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept. 25 *, 19*49 *to* Nov. 9 *, 19*49*, that I last saw the deceased alive on* Nov. 9 *, 19*49*, and that death occurred at* 8 P. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. P. Grove M. D. | Union Memorial Hospital | 11/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/12/49 | Trinity Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 12 1949 | Deputy Registrar | HENRY SANDER & SONS, INC. |

VS 150

52a

G79778

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79778

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Joseph Carpintieri

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: 21yr. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1635 E. Oliver Street 807

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 28. 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Sparrows Point | Italy | |

13. FATHER'S NAME: Anthony Carpintieri

14. MOTHER'S MAIDEN NAME: Mary Mangafico

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | WW I | 213-09-1554 | Mrs. Rosarie Carpintieri | 1635 E. Olive |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of stomach | 1 mo.? |
| DUE TO (B) | Pernicious anemia | 10 yrs.? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | None | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/9/ 1949 *to* 11/11/ 1949, *that I last saw the deceased alive on* 11/11/ 1949 *and that death occurred at* 10:15 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Joseph Kreger M.D. | 1400 N. Caroline Street | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 14. 1949 | Baltimore National | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 12 1949 | Christopher Williams M.D. | HENRY SANDER & SONS. INC. |

VS 150

Baltimore Md.

46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79779 G79779

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 794

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles M. Goodfellow

2. DATE OF DEATH: Nov 9th 1949 8 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 808 Gorsuch Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 808 Gorsuch Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 808 Gorsuch Ave 9-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) (Last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | about 1853 | 96 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Chauffeur | England | |

13. FATHER'S NAME: (Unknown) Goodfellow
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Alfred Goodfellow | 808 Gorsuch Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Natural —
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Senility. —
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10 19 46 *to* Nov 9 19 49, *that I last saw the deceased alive on* Nov 9 19 49 *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony F Carozza M. D.
23B. ADDRESS: 5917 York Rd
23C. DATE SIGNED: 11/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/12/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 11 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Wm Cook Inc
ADDRESS: 1217 St. Paul St

VS 150

162B

G79780

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1 59 Registered No. G79780

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GALLAGHER, MARY
2. DATE OF DEATH: NOV. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE, Md. 12-03
D. STREET ADDRESS (If rural, give location): 2737 ST. PAUL ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | AUG. 22, 1898 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): YORK, PA.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: HARRY PEACH
14. MOTHER'S MAIDEN NAME: ELLA P. CKING
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.
17. INFORMANT: HUSBAND — ADDRESS: SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | GENERALIZED CARCINOMATOSIS | 12 YRS |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | | |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: OCT. 4 1949
19B. MAJOR FINDINGS OF OPERATION: PELVIC - ABDOMINAL MASS - COLOSTOMY PER-
20. AUTOPSY? YES [X] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location): FARMER.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 29, 1949 to NOV. 10, 1949 that I last saw the deceased alive on NOV. 10, 1949, and that death occurred at 3:30 m., from the causes and on the date stated above.

23A. SIGNATURE: Mary E. Matthews M.D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/13/49
24C. NAME OF CEMETERY OR CREMATORY: Balto.
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: [illegible], M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 St. Paul St.

VS 150

46E

PLEASE WRITE LEGIBLY. WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79781 G79781

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79781

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM GAYLARD BIGGS

2. DATE OF DEATH: NOV. 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4607 YORK ROAD
C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 4607 YORK ROAD 77-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | MAR. 31, 1875 | 74 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION
10B. KIND OF BUSINESS OR INDUSTRY: G & E Co.
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: WILLIAM HENRY BIGGS
14. MOTHER'S MAIDEN NAME: ROSANA OILLEHUNT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-03-3027A
17. INFORMANT: ANNA LENORA BIGGS ADDRESS: SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 7 mo.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1949, to Nov., 1949, that I last saw the deceased alive on Nov 9, 1949, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Clarence W. LeDoux M. D.
23B. ADDRESS: 3023 Eastern Ave.
23C. DATE SIGNED: 11/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11-14-1949
24C. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR:
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: HENRY W. JENKINS & SONS CO. ADDRESS: 4905 YORK RD.

VS 150

130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ES-133168
G79782

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 193

G79782

Registered No.

1. NAME OF DECEASED (Type or Print): Winona Manown

2. DATE OF DEATH: 11-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

C. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 538 Hurley Avenue (23) 20-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Wid | Oct. 27, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | W.Va. | |

13. FATHER'S NAME: William McClain

14. MOTHER'S MAIDEN NAME: Mary Trobridge

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | RECORDS*BALTO. CITY HOSPITALS EASTERN AVE. 4940 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Surgical Shock
DUE TO
(B) Parasagital Meningioma
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-11-49 | Recurrent Meningioma | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-3, 19 49 *to* 11-11, 19 49 *that I last saw the deceased alive on* 11-11 19 49 *and that death occurred at* 12:45 P *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Rogers M. D. | 4940 EASTERN AVENUE | 11-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/14/49 | Kirkwood Cem | Kirkwood West Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 12 1949 | Registrar | L. P. Towell 2427 Edmondson Ave |

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER.

56D

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79783 ✓ G79783

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 231

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Ann Lucey

2. DATE OF DEATH: Nov. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 123 W. Ostend St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 123 W. Ostend St 23-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | April 15, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | | |

13. FATHER'S NAME: Daniel Savage

14. MOTHER'S MAIDEN NAME: Mary Ann

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. E. Westfall 123 W. Ostend St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
ANTECEDENT CAUSES
(B) Arteriosclerosis
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Senility

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Left Hemiplegia

INTERVAL BETWEEN ONSET AND DEATH: (A) 1 week; (B) 2 years; (C) 2 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 3, 1949 *to* Nov 10, 1949, *that I last saw the deceased alive on* 11/9/1949, *and that death occurred at* 5:30A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Miller MD M. D. | 1228 S Charles St | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 14/49 | Cathedral | Baltimore |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 12 1949
REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR ADDRESS: Rita Wiedefeld 900 E. Biddle St

VS 150

Dr Miller 1228 S. Charles 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79784 Deceased ✓ G79784

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

45-6 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ruth E Raines (Emma Chinn) | 2. DATE OF DEATH: 11/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Life | Yrs. 21 | Mos. | Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 508 W. Lexington

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Yellow | Divorced | March 30 1928 | 21 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore, Md. | USA |

13. FATHER'S NAME: Henry Chinn
14. MOTHER'S MAIDEN NAME: Emma Haun

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Henry Chinn, father | 508 W. Lexington St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute disseminated Lupus erythematosis | 7 months |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | pericardial effusion | 1 week |
| DUE TO (C) | Chronic passive congestion of liver | 1 week |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | over |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/10, 1949 *to* 11/11, 1949, *that I last saw the deceased alive on* 11/11, 1949, *and that death occurred at* 12:35 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Richard Fravel M. D. | Mercy Hosp. | 11/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 12/49 | Lorraine Cemetery | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 12 1949 | Huntington Williams, M.D. | Stewart & Mowen Co. | 108 W. North Ave. |

VS 150

90R City #1.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79785

BIRTH NO. 79-23558

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 763.5

1. NAME OF DECEASED (Type or Print): BABY GIRL RAICES

2. DATE OF DEATH: 11/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's

C. Length of stay in Baltimore: Yrs. — Mos. — Days 7

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-07
D. STREET ADDRESS (If rural, give location): 208 N. Lexington St.

5. SEX: F
6. COLOR OR RACE: Yellow
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11-2-49
9. AGE (If under 1 year, last birthday): 8 Under 1 Year — Months — Days 7 — Hours — Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: Newborn
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard Robert Raices
14. MOTHER'S MAIDEN NAME: Ruth Emma Linn 23558

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Ruth Emma C. Raices - mother
ADDRESS: Balto. Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) PREMATURITY —
DUE TO
(B) Lobar pneumonia
DUE TO
(C)

~~ANTECEDENT CAUSES~~
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-7-, 1949, to 11-9-, 1949, that I last saw the deceased alive on 11/9/1949, and that death occurred at 5:26 m., from the causes and on the date stated above.

23A. SIGNATURE: Frank W. Bakes, Jr. M.D.
23B. ADDRESS: St. Joseph's Hospital
23C. DATE SIGNED: 11/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 12/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Stewart & Mowen Co.
ADDRESS: 108 W. North Ave

VS 150

159 City #1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79786 X ✓ G79786

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4ro.1

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): HARRIET PRISCOE
2. DATE OF DEATH: November 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: 40 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fullerton
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 4/23/70
9. AGE (In years last birthday): 79 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Taylor
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Grace Clayton ADDRESS: 7406 Linden Av

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral arteriosclerosis
DUE TO Coronary arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22 *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED 11-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/13/49
24C. NAME OF CEMETERY OR CREMATORY: Putty Hill
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS: 7401 Belair Rd.

VS 151

94a ✓

G79787

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79787

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): AMELIA A. WATSON

2. DATE OF DEATH: 11-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 808 East 35th Street
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 808 East 35th Street 9-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | - | Baltimore, Md. | |

13. FATHER'S NAME: Louis G. Cook

14. MOTHER'S MAIDEN NAME: Lucretice Eggleston

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: Mr. Ed. Cook 3101 Shannon Drive

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Myocarditis | 6 mos. |
| ANTECEDENT CAUSES | DUE TO (B) Broncho Pneumonia | 1 mo. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) Senile Dementia | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1 May, 19 49, *to* 11 Nov, 19 49, *that I last saw the deceased alive on* 11 Nov, 19 49, *and that death occurred at* 9:10 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edna Hoaps M. D. | 3534 Ellerslie Ave | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-14-49 | Loudon Park Cem. | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 12 1949 | Lucretia Williams, M.D. | WIEDEFELD AND SON | GREENMOUNT AVE. & 22nd ST. 93E |

VS 150

Please write plainly, with ink and use no abbreviations. Every item of information should be given. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79788

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79788 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PATRICK CARBERRY

2. DATE OF DEATH: 11-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 East 22nd Street

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 803 East 22nd Street 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sexton | St. Ann's Church | Ireland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick Carberry | Mary Quirk |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| no | - | none | Mrs. Bridget Carberry 803 East 22nd Street |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 8 Years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocarditis — 6 Yrs.

DUE TO

(C) Rheumatoid Arthritis — 12 Yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| 20 | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July, 1949 *to* Nov. 10, 1949, *that I last saw the deceased alive on* Nov. 9, 1949, *and that death occurred at* 3:40 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas J. Mahr M. D. | 3709 Greenmount Ave | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-14-49 | Cathedral | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 12 1949 | Timothy Williams, M.D. | WIEDEFELD AND SON | GREENMOUNT AVE. & 22nd ST. 93c |

VS 150

Please write plainly, with ink. Every item of information should be given correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BIRTH NO. G79789

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

G79789 Registered No.

1. NAME OF DECEASED (Type or Print): James Reaney

2. DATE OF DEATH: Nov 11.1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3503 N.Charles St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ---------
c. Length of stay in Baltimore — Yrs. life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 3503 N. Charles St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | white | Married | July 3. 1861 | 88 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retires | Limestone | Md. | U.S.A. |

13. FATHER'S NAME: James Reaner Sr.

14. MOTHER'S MAIDEN NAME: Rachel Wardord

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Susan C. Ballard | Owings Mills Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 3½ hrs |
| DUE TO (B) | Arterio sclerosis | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cardiac Arrhythmia Auricular Fibrillation. Prostatic hypertrophy | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 28, 1949 *to* Nov. 11, 1949 *that I last saw the deceased alive on* Nov 11, 1949, *and that death occurred at* 4:10 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John W. Parsons M. D. | 1109 St Paul St | 11-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Nov. 12. 1949 | Loudon Park Cemetery | 3801 Frederick Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 12 1949 | Huntington Williams, M.D. | John O. Mitchell | John O. Mitchell & Sons 1900 Eutaw Place |

VS 150

83a

Please write plainly, in ink. Every item must be answered. Certainty supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79730

BIRTH NO. 49-23330

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79730

Registered No.

1. NAME OF DECEASED (Type or Print): Baby (Brent Ernest) Hasenzahl — 159.3

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Maryland. Baltimore 17, Md.
C. Length of stay in Baltimore: Yrs. — Mos. — Days: 15 da. 6 hr 27 min

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville 28,
D. STREET ADDRESS (If rural, give location): 6609 Lochinvar Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Oct 27, 1949 | | | 15 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Maryland | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ernest Ludwig Hasenzahl | Doris Amelia Obst |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Doris Amelia Hasenzahl | 6609 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition & Dehydration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Prematurity

DUE TO

(C) Multiple Congenital Abnormalities

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 27, 1949, *to* Nov 11, 1949, *that I last saw the deceased alive on* Nov 11, 1949, *and that death occurred at* 3:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Anna Jagelberg M. D. | Hosp. for Women of Maryland | Nov. 12, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12 Nov 49 | Woodlawn | Woodlawn - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 7 | Deputy for Williams, M.D. | F. Ellingsworth & Son | 1300 Eutaw Pl. |

VS 150

159

Please write plainly in ink. Every item of information should be given as correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79791

G79791

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES GIDEON EMPIE

2. DATE OF DEATH: November 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 23rd. & St. Paul St. Dr. Beck's Clinic

c. Length of stay in Baltimore: 22 yrs (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 347 S. Bonsal Street 26-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Mar. 10, 1874 | 75 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sharon Hill, N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Myron O. Empie

14. MOTHER'S MAIDEN NAME: Emma Kling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mrs. Grace D. Empie 347 S. Bonsal Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

(B) Chr. Myocarditis — Indefinite

DUE TO

(C) Chr arteriosclerosis — Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 5, 1949 *to* Nov 11, 1949 *that I last saw the deceased alive on* Nov 11, 1949, *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Nathaniel M Beck M. D.

23B. ADDRESS: 100 E 23rd St Baltimore

23C. DATE SIGNED: Nov 12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial

24B. DATE: 11/15/49

24C. NAME OF CEMETERY OR CREMATORY: Slate Hill Cemetery

24D. LOCATION (City, town, or county) (State): Cobleskill, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 1

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.

ADDRESS: Baltimore Md.

VS 150

93D

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Important, correct age is especially important.

G79792

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 751

G79792 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Engleking

2. DATE OF DEATH: 11/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): Highland Road Marley Park

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | S | 3/27/49 | | 7 | 16 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Howard Engel King
14. MOTHER'S MAIDEN NAME: Dorothy Googhagan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Internal Hydrocephalus - Severe
DUE TO
(B) Meningitis
DUE TO
(C) Spina Bifida

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Malnutrition, Emaciation & dehydration

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [x] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/27, 1949, *to* 11/11, 1949, *that I last saw the deceased alive on* 11/11, 1949, *and that death occurred at* 4:35 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William B. Cooper M.D.
23B. ADDRESS: South Baltimore Gen. Hosp.
23C. DATE SIGNED: 11/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: Nov 17, 1949
24C. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN
24D. LOCATION (City, town, or county) (State): GLEN BURNIE, MD

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Thomas W. Singleton
ADDRESS: Glen Burnie Md

VS 150

157a

G79793

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79793

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALICE MAUD LOANE

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: 74 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-0
D. STREET ADDRESS (If rural, give location): 1509 E. North Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | February 24, 1875 | 74 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher(rtd)

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Sickel, Edward

14. MOTHER'S MAIDEN NAME: Trust, Alice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Loane, Mr. Edward ADDRESS: 413 Northern Pkwy Baltimore, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary Infarction | 2 days |
| DUE TO (B) | Arteriosclerotic Heart disease & heart failure | 14 days |
| DUE TO (C) | Arteriolar sclerotic renal disease & Uremia | 14 days |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 8, 1949, *to* November 12, 1949, *that I last saw the deceased alive on* November 12, 1949, *and that death occurred at* 6:20 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ronald L Leaton M. D.

23B. ADDRESS: Church Home & Hospital

23C. DATE SIGNED: Nov. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/15/49

24C. NAME OF CEMETERY OR CREMATORY: Green Mount Cem.

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 13 1949

REGISTRAR'S SIGNATURE: [illegible]

25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS

ADDRESS: Balto., Md.

VS 150

131a

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79794 E 812.1 G79794 Registered No.

BIRTH NO. G79794 N-17431

1. NAME OF DECEASED (Type or Print): EARL PARKER, JR. N-5541

2. DATE OF DEATH: November 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1556 McKeene Avenue 15-02

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 12/7/44
9. AGE (In years last birthday): 4 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Earl Parker, Sr.
14. MOTHER'S MAIDEN NAME: Elois Brooks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT'S ADDRESS: Earl Parker - 1556 McKeene Ave -

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid hemorrhage with subarachnoid adhesions
DUE TO
ANTECEDENT CAUSES
(B) Internal hydrocephalus
DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Brain abscess
II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Infarcts of the kidney

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 63-00 Washington Boulevard, Waterloo, Maryland
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-7-49 8:30 P. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/13/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State): Arbutus, Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles L. Law
ADDRESS: 802 Madison Ave

VS 151

170c

G79795

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 231

G79795 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN WESLEY ROBERTS

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2418 Baker St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2418 Baker St. 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Feb. 2, 1882 | 67 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired farmer | Sudbrook Farm | Maryland | |

13. FATHER'S NAME: William Roberts

14. MOTHER'S MAIDEN NAME: Sarah E. Barnes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Frances White | 2418 Baker St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CEREBRAL HEMORRHAGE | 6 days. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-6, 1949, *to* 11-12, 1949, *that I last saw the deceased alive on* 11-12, 1949, *and that death occurred at* 1:30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Norman R Kleeman M. D. | 3803 Edmondson Ave | 11/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | Asbury Cem. | Reisterstown, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 13 1949 | Huntington Williams M.D. | Wm. J. TICKNER & SONS | Balto., Md. |

VS 150

82a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79796

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51

Registered No. G79796

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Louise Wilson

2. DATE OF DEATH: November 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Phoebus
D STREET ADDRESS (If rural, give location): 21 E. Virginia Ave.

| 5 SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 3-17-1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Va. | |

13. FATHER'S NAME: Thomas Dixon

14. MOTHER'S MAIDEN NAME: Ruby Burtten

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Stomach | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-8, 1949, *to* 11-12, 1949, *that I last saw the deceased alive on* 11-12, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gordon Malone Carver Jr. M.D. | JOHNS HOPKINS HOSPITAL | 11-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov 13 1949 | Hampden, Va. | Hampden, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 13 1949 | Lemington for Williams, M.D. | W. H. J. Tickner & Sons | Baltimore (17) |

VS 150

463

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 793797 — Registered No. G79797

1. NAME OF DECEASED (Type or Print): Joseph Donat

2. DATE OF DEATH: Nov 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6210 Everall Ave.
c. Length of stay in Baltimore: Yrs. 27 Mos. — Days 34

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto.
B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO Md.
D. STREET ADDRESS (If rural, give location): 6210 EVERALL Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | MARRIED | Dec 25, 1862 | 86 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MINISTER. | | Czechoslovakia | U.S.A. |

13. FATHER'S NAME: ANTON DONAT

14. MOTHER'S MAIDEN NAME: KATAERINE SONSEK

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Mrs Joseph DONAT | WIFE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Bronchio Pneumonia | 3 days |
| DUE TO (B) | Chronic Myocarditis | 15 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | General Arteriosclerosis | — |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 10, 1949 *to* Nov 12, 1949 *that I last saw the deceased alive on* Nov 12, 1949, *and that death occurred at* 10A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank J. Ayd, M. D. | 2005 E. Monument St | Nov 13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | Moreland Memorial | Taylor Ave Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 13 1949 | [illegible] for Williams, M.D. | Mildred T. Blight | 6009 Harford Rd |

93D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79798 G79798

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wilmer C. CLARK.

2. DATE OF DEATH: 11-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Pasadena
D STREET ADDRESS (If rural, give location): Bar Harbor

| 5. SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| MALE | White | widowed | 11-18-1874 | 74 | 11 24 | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED - WATCHMAN | FRANKFORD DISTILLERY | md. | |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| AUGUS - CLARK. | Mary |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| | 213-16-8195 | ROBERTA MICHAEL-6712 | MARLEY NECK RD BROOKLYN |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Duodenum 1st PORTION.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Bilateral Pulmonary Congestion; Emphysema Lungs.

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 11/8/49. | Carcinoma Duodenum 1st portion. | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. I hereby certify that I attended the deceased from 11/4, 1949 to 11/11, 1949, that I last saw the deceased alive on 11/10, 1949, and that death occurred at 5:25 A.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| R. V. Ramsey M. D. | St. Agnes Hospital | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-14-49 | GLEN HAVEN CEM | GLEN BURNIE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 13 1949 | Huntington Williams, M.D. | Bernard C. Hahn | 121 E West St |

VS 150

46c

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79799 BALTIMORE CITY HEALTH DEPARTMENT G79799

# CERTIFICATE OF DEATH

331

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs Mary Millenson
2. DATE OF DEATH: 11-13-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Aged Home
C. Length of stay in Baltimore: 54 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3838 Menlo Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Oct 15, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | NONE | Russia | USA |

13. FATHER'S NAME: Nathan Gard
14. MOTHER'S MAIDEN NAME: Mallie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Paul M. Weiner — ADDRESS: 4303 Edgehurst Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B) Cerebral Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1. 16 1948, to 11-13 1949, that I last saw the deceased alive on 11-13, 1949, and that death occurred at 12 a m., from the causes and on the date stated above.

23A. SIGNATURE: Jerome Joachim Blumberg, M. D.
23B. ADDRESS: Levindale House
23C. DATE SIGNED: 11-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-13-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson & Bros.
ADDRESS: W. North Ave.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

# NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G79800 G79800

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 51

1. NAME OF DECEASED (Type or Print): Adolf Schwartz
2. DATE OF DEATH: 11-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 805 West North Ave
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-0
D. STREET ADDRESS (If rural, give location): 805 W North Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shoe maker | | Hungary | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Abraham | Rebecca |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Rosa Schwartz 805 W North |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B) Generalized Metastasis — 1 years.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1 Nov 1949, *to* 12 Nov, 1949, *that I last saw the deceased alive on* 12 Nov, 1949, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Laurita L. Brown M. D. | 4358 Fredericks Ave | 12 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-13-49 | Hebrew Young Men | Pikesville Md |

| 25. RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 26. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 13 1949 | Huntington Williams M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

46B

Important. Physicians: please write the causes of death clearly and legibly.

G79801

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79801 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Irvin Ross

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

C. Length of stay in Baltimore: 30 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1516 Webster St. 24-14

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH:
9. AGE (In years last birthday) If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.: 48

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): London Eng
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Joseph Segel ADDRESS: 3721 Belle Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio sclerotic Cardio-
DUE TO Vascular Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Nov. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-13-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 13 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin ADDRESS: 2100 Eutaw Pl

93D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. 151

G79802

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

G79802 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Romaine L. Smith.

2. DATE OF DEATH: November 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3706 Hickory Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 3706 Hickory Ave. 13-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married.
8. DATE OF BIRTH: June 8 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Josephus Rigel.
14. MOTHER'S MAIDEN NAME: Mary Love.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: George L. Smith ADDRESS: 3706 Hickory Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO
(B) Arteriosclerosis — Indefinite
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Nov, 1949, to 10 Nov, 1949, that I last saw the deceased alive on 10 Nov, 1949, and that death occurred at 1 P m., from the causes and on the date stated above.

23A. SIGNATURE: Paul B Worthington M. D.
23B. ADDRESS: 2020 N. Charles St
23C. DATE SIGNED: 12 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/14/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn.
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Frank E. Lawrence ADDRESS: 3611-13 Harford Ave.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

G79803

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79803

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) EDGAR L. Ward

2. DATE OF DEATH 11-10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City 13-08
D. STREET ADDRESS (If rural, give location) 3528 Poole St #11

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 3-21-83 | 9. AGE (In years last birthday) 66 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant (Retired) | 10B. KIND OF BUSINESS OR INDUSTRY American Can Co.

11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Ward.

14. MOTHER'S MAIDEN NAME Jane Murry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216 03 6113

INFORMANT Elizabeth Ward ADDRESS 3528 Poole St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive failure & auricular fibrillation + renal failure — INTERVAL BETWEEN ONSET AND DEATH: several mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease and Rheumatic heart disease? — unknown cir 15-20 yrs.

DUE TO

(C) Nephrosclerosis with Diabetes mellitus - Uremia -

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-5, 1949 *to* 11-11, 1949 *that I last saw the deceased alive on* 11-10-49, 1949 *and that death occurred at* 11:55 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE Marguerite Louise Cadle M.D. | 23B. ADDRESS Md. Gen. Hosp. | 23C. DATE SIGNED 11-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 11/14/49 | 24C. NAME OF CEMETERY OR CREMATORY St Mary's | 24D. LOCATION (City, town, or county) (State) Hampden.

DATE RECEIVED BY LOCAL REGISTRAR NOV 13 1949 | REGISTRAR'S SIGNATURE Carrington Williams, M.D. | 25 FUNERAL DIRECTOR Jones & Sons ADDRESS 3612 12 Eastern Ave.

VS-15b

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

61

G79803 | BALTIMORE CITY HEALTH DEPARTMENT | G79804

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Emma T. Saulsbury

2. DATE OF DEATH: November 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Gunder Sanitarium Hotel, Baltimore 29, Md.
c. Length of stay in Baltimore: 6 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reisterstown
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | white | Single | 11-25-1845 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | — | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James H. Saulsbury | Emma J. Gullett |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | — | A. O. Saulsbury (nephew) | Reisterstown, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — DUE TO arteriosclerosis — Interval: Several years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Previous cerebral accident & good recovery except for spasticity in left leg — DUE TO — Interval: 5 months

(C) Chronic bronchitis - general debility — Interval: years

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April 22, 1943, *to* November 13, 1949, *that I last saw the deceased alive on* November 13, 1949, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H. Gundry, M. D. | The Gunder Sanitarium, Gittings & Baltimore 29 | 11-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-14 | DENTON | DENTON, MARYLAND |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | John J. Mitchell & Sons, Inc. | 82a / 900 Eutaw Pl. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79805

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 120. 1 G79805

1. NAME OF DECEASED (Type or Print) John Howard Alexander

2. DATE OF DEATH Nov. 13 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University - Hospital.

C. Length of stay in Baltimore 1 year — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore. 25 - 43
D. STREET ADDRESS (If rural, give location) 2010 Breidwert ave.

5. SEX Male.
6. COLOR OR RACE White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED.
8. DATE OF BIRTH 9/26/1863
9. AGE (In years last birthday) 86.
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Spinner
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John S. Alexander
14. MOTHER'S MAIDEN NAME Margaret Howard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Lenora A Schwartz ADDRESS 2010 Brentwert ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Anterior Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1½ weeks
DUE TO
(B) Arteriosclerosis.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-6, 1949, to 11-13, 1949, that I last saw the deceased alive on 11-13, 1949, and that death occurred at 8:10 A m., from the causes and on the date stated above.

23A. SIGNATURE H. Patterson Mack. M. D.
23B. ADDRESS University Hospital
23C. DATE SIGNED 11-13-49

24A. BURIAL, CREMATION OR REMOVAL (Specify) Burial
24B. DATE Nov 15-1949
24C. NAME OF CEMETERY OR CREMATORY Worthington Lutheran Cem
24D. LOCATION (City, town, or county) Armstrong Co Kittanning Penna

DATE RECEIVED BY LOCAL REGISTRAR NOV 13 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Edward Toulson ADDRESS 35 Washington Blvd

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79806

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E- 851 G79806 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Manley T. Ellis N-990

2. DATE OF DEATH: Nov. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital DOA

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | | 32 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| U.S. Navy | | | U.S.A. |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | World War II | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia due to Drowning.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Harbor | U.S. Ship TCK856 at Ft. McHenry Harbor |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 13, 1949 7 Am. | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | Fell from ship into harbor |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

Autopsy, Inspection or Inquiry

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Saul L Rayer M.D. | ☐ ☐ ☐ | 13 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | Phila., Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Hunter for Williams, M.D. | USN Hospital Annapolis Md | |

VS 151

183 ✓ Pen to H. Dunbeck

correct age is especially important. Physicians: please write the causes of death clearly and legibly:

G79807

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

Registered No. G79807

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Nicholas Beiser

2. DATE OF DEATH: Nov. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Beltimore 12-07
D. STREET ADDRESS (If rural, give location): 214 E. University Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb 23, 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Real Estate | | Tennessee | U. S. A. |

13. FATHER'S NAME: Edward N. Beiser

14. MOTHER'S MAIDEN NAME: Ketherine Eheman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 214-01-6382

17. INFORMANT: Edenna Agnes Beiser — ADDRESS: 214 E - University Pky

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured aorta, dissecting — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease — years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Nov 10, 1949, *to* Nov. 10, 1949 *that I last saw the deceased alive on* Nov 10, 1949, *and that death occurred at* 6 30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. F. Coffey M.D. M. D. | Union Memorial Hospital | 11-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov 15-49 | Loudon Park | Balto - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Ernsworth Funeral | 5118 Sturgeon Oak Ave. 96 |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79808 ✓ G79808

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

540.1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Vassos Achilles

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

c. Length of stay in Baltimore: 2 1/2 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1816 St. Paul St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 1923 | 26 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Employee

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cyprus

12 CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Pandelides Achilles

14 MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO:

17 INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Peritonitis | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) Perforated gastric ulcer | 11 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 11-1-49 11-7-49 | Perforated gastric ulcer Perforated gastric ulcer; peritonitis, abscess R.U.Q. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* Nov 11, 1949, *that I last saw the deceased alive on* Nov 11, 1949, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Glenn P. Grace M. D. | Union Memorial Hospital | Nov 11 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov 14-49 | Greek | Balto - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Sambros Funeral Home Inc | 440 E. North Ave 117a |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

AB-116378

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79809

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Lericos

2. DATE OF DEATH: 11-10-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3025 Hamilton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 27yrs (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | White | Widower | Nov. 14- 1855 | 83 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Greece
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Lericos
14. MOTHER'S MAIDEN NAME: Helen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Chronic glomerulonephritis
DUE TO
(C) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-6- , 19 49 *to* 11-10- , 19 49 *that I last saw the deceased alive on* 11-10- 19 49 *and that death occurred at* 9.20 AM *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Logan M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: Nov 14 1949
24C. NAME OF CEMETERY OR CREMATORY: Greek -
24D. LOCATION (City, town or county) (State): Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Samuels Funeral Home Inc.
ADDRESS: 440 E. North Ave.

VS 150

121a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79810

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79810

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Genevieve (Jennie) Churchill

2. DATE OF DEATH Nov 12, 1949

3. PLACE OF DEATH
A Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 3112 Belmont Ave 16 07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3117 Belmont Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1/29/1880?
9. AGE (In years last birthday): 69
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Towson Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Clarke
14. MOTHER'S MAIDEN NAME: Jennie Nally

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: John D. Sapp ADDRESS: 7677 Wilkins Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | Sudden |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Chronic Myocarditis | ? |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cancer of Uterus | 3 yrs |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 2, 1949, *to* Nov. 12, 1949, *that I last saw the deceased alive on* Nov. 7, 1949, *and that death occurred at* 3:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Maurice E. Shamer M. D.
23B. ADDRESS: 3300 W. North Ave
23C. DATE SIGNED: 11-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robt C & J. M. Weston ADDRESS: Pikesville

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

48 B

G79811 BALTIMORE CITY HEALTH DEPARTMENT G79811

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Louise Pauline Lipp
2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 505 McCabe Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 505 McCabe Ave 27-10

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9/29/1857
9. AGE (In years last birthday): 92 — Under 1 year: Months 1, Days 13; Under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Krausse
14. MOTHER'S MAIDEN NAME: Pauline Sigmond
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO
17. INFORMANT: Margaret K. Fiedt ADDRESS: 505 McCabe Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) General Arteriosclerosis
DUE TO
(B) Senility
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 2, 49 *to* Nov 11, 49, *that I last saw the deceased alive on* 19 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: Anthony F. Corozza, M.D.
23B. ADDRESS: 5217 York Rd
23C. DATE SIGNED: 11.12.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/14/49
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): A.G. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

97

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79812

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

19

Registered No. G79812

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dorthy A. Newlin

2. DATE OF DEATH Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland.
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 214 S. Fulton Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. 19 Mos. 0 Days 4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 11/14/1921 | 27 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home. | — | |

13. FATHER'S NAME Oliver Crampton

14. MOTHER'S MAIDEN NAME Reba Swain

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Chas. E. Newlin | 214 S. Fulton Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Melano-Sarcoma - Liver. — INTERVAL BETWEEN ONSET AND DEATH: Approx. 4½ yrs.

DUE TO

(B) Melano-Sarcoma - Left Eye

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/27, 1949 *to* 11/11, 1949 *that I last saw the deceased alive on* 11/11, 1949, *and that death occurred at* 6:50 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | West Baltimore Gen. Hosp. | 11/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~OR CREMATORY~~ | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 11/15/49 | Mountain View | Sharpsburg Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 1217 St. Paul St. |

VS 150

55E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79813 ✓ 1 G79813

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Taylor

2. DATE OF DEATH: Nov.11,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1833 E. Notth Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1833 E. North Ave. 8-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Femele | White | Widow | Aug.19,1871 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore,Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Wyman | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | James E. Taylor, | 1833 E. North Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerotic Cardiovascular Renal

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/23 19[illegible] *to* 11/11 19[illegible], *that I last saw the deceased alive on* 11/11 19[illegible] *and that death occurred at* 10:45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Weiss, M. D. | 1927 E. North Ave | 11/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | Baltimore | Baltimore,Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St.Paul St. |

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

93D

G79814

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4143 G79814

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James E. Miller

2. DATE OF DEATH: Nov. 12 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mulvue Hotel
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): Mulvue Hotel, Cathedral 50

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | March 8, 1880 | 69 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lawyer in home | RR | Pa | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Harold J. Miller | 4118 White Ave |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Young M.D | | 13 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Forhwood | Forhwood Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Investigator Williams, M.D. | Wilbur Coffin | 1217 E. Fayette |

VS 151

correctness is especially important. Physicians: please write the causes of death clearly and legibly.

939

G79815

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

149-5 Registered No. G79815

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BAILEY P. DUDDERER

2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

C. Length of stay in Baltimore: Yrs. — Mos. — Days: 4 Weeks

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sykesville
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Widowed | Sept. 23, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Retired | Md | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Dudderer | Josephine Dashiell |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | John Dudderer | Sykesville Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Undetermined~~, uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Metastatic malignancy (over)

DUE TO

(C) Unknown Causes

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arterio-Vascular sclerosis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Oct. 30, 1949, to Nov. 11 1949, *that I last saw the deceased alive on* Nov. 11, 1949, *and that death occurred at* 3:10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles T. Henderson M. D. | University Hospital | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-15-49 | Springfield | Sykesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | C. H. Weer | Sykesville, Md. |

VS 150

55E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79816

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20

G79816 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LILLIE A. FRANCE

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2209 St. Paul St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2209 St. Paul St. 12 0 4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 21, 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| (Unknown) Beggs | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Lewis H. France, 2209 St. Paul St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Cardio-vascular disease — 4 yrs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1946, 19 *to* Nov. 12, 1949 *that I last saw the deceased alive on* Nov. 12, 1949 *and that death occurred at* 8 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Homer L. Todd M. D. | 2108 St Paul St | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/14/49 | Green Lawn | Newport News, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

C79817

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79817

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillian Caplan

2. DATE OF DEATH: November 12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6108 Gist Avenue 77-20

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: May 13, 1896
9. AGE (In years last birthday): 53
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles Caplan - 6108 Gist Ave. ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Pyonephrosis
DUE TO
(C) Renal Calculi

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE 1A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 1945 *to* 11-12, 1945, *that I last saw the deceased alive on* 11-12, 1945, *and that death occurred at* 1:30P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Leonard Koz M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 11-12-45

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: NOV 14/1949
24C. NAME OF CEMETERY OR CREMATORY: Reform Hebrew Burying Ground
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros. ADDRESS: 1124-26 W. North Ave

VS 150

124a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79818

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17°

Registered No.

G79818

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leah Liebman

2. DATE OF DEATH Nov. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2509 Loyola Northway

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2509 Loyola Northway 15-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | married | 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | England | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Nathan Goldstein | Sarah ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Joseph Liebman | 1507 Loyola Northway |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial infarct | 1 day |
| DUE TO (B) | Carcinoma of head | 10 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1939 | Tubal ligation | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb. 1939 *to* Nov 13, 1949, *that I last saw the deceased alive on* Nov 12 1949 *and that death occurred at* 6:50 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 2040 Eutaw Pl | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-15-49 | Beth Tfiloh Cong. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Sol. Fleischer & Bro. | W. North Avenue |

VS 150

50

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79819

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79819

1. NAME OF DECEASED (Type or Print): BENJAMIN HAMILTON 4343

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 436 E. 23rd. Street
c. Length of stay in Baltimore: 65 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 436 E. 23rd. Street 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | January 10, 1856 | 93 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Poultry dealer | Poultry | Essex Co. Va. | U.S.A. |

13. FATHER'S NAME: Benjamin Hamilton

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Mildred Hamilton
ADDRESS: 436 E. 23rd. Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Organic Heart Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: History Indefinite

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 10, 1948, *to* Nov. 11, 1949, *that I last saw the deceased alive on* Nov. 11 1949, *and that death occurred at* 3:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: R. Garland Cornell M. D.

23B. ADDRESS: 1534 Druid Hill Ave,

23C. DATE SIGNED: Nov. 12. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 14th. 1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY REGISTRAR: NOV 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR
ADDRESS: Holland Funeral Home
1631 Druid Hill Ave.

95c

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79820

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 816.0 G79820

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH REMEIKIS 1862-4

2. DATE OF DEATH: November 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1055 Ellicott Driveway 16-47

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 15, 1915
9. AGE (In years last birthday): 34
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman
10B. KIND OF BUSINESS OR INDUSTRY: Balto.City Fire Dept.
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Remeikis
14. MOTHER'S MAIDEN NAME: Anna Bobelis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mary Remeikis, (wife)
ADDRESS: 1055 Ellicott Drive

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Crushing injuries of chest
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fracture of leg, right
Fractured nose

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Park Heights Avenue & Rogers Avenue 27/15
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-9-49 3:15 P m.
21E. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Collision between hook & ladder & hose truck of fire dept.

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: RUSSELL S. FISHER, M.D.
Per: George W. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 12-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Joseph Kasunskas Inc.
ADDRESS: 602 Wash. Blvd

VS 151

170 c

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79821

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79821

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Michael J. Cooney
2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 919 Hillwood Pkway. 16-08

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 4/10/89
9. AGE (In years last birthday): 60 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mayor's office
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: John Cooney
14. MOTHER'S MAIDEN NAME: Anna Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Dorothea Cooney ADDRESS: 919 Hillwood Pkwy.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary thrombosis — 3 days

DUE TO

(C) Arteriosclerosis, Generalized — —

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(1) Diabetes Mellitus (2) Uremia

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/10/49, 1949, *to* 11/12, 1949, *that I last saw the deceased alive on* 11/12, 1949, *and that death occurred at* 3:05 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas S. Connor M. D.
23B. ADDRESS: Mercy Hospital, Balto.
23C. DATE SIGNED: 11/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 15-1949
24C. NAME OF CEMETERY OR CREMATORY: Western Cemetery
24D. LOCATION (City, town, or county) (State): Edmondson Ave Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Thomas J. Williams, M.D.
25. FUNERAL DIRECTOR: Joseph Farace Inc. ADDRESS: 2013 Greenmount ave

VS 150

61

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79822

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 776

G79822

BIRTH NO. 49-28277

1. NAME OF DECEASED (Type or Print): Baby Girl Johnson

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): [illegible] HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5 01
D. STREET ADDRESS (If rural, give location): 114 N. Eden St

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 11-6-49
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 7

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: Cleopatra Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT [illegible] HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/6, 1949, *to* 11/6, 1949, *that I last saw the deceased alive on* 11/6, 1949, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: Clifton Prystowsky M. D.
23B. ADDRESS: [illegible] HOSPITAL
23C. DATE SIGNED: 11/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Rose Hill
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR
ADDRESS

VS 150

159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79823

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79823 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Green

2. DATE OF DEATH: Nov 12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 15 W. Lee
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
15 W. Lee St. Balto. Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 15 W. Lee St 22-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | 6-22-1879 | 70 | 5 | 20 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | — | Va | |

13. FATHER'S NAME: Nelson Green

14. MOTHER'S MAIDEN NAME: Lela —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | 217-09-5852 | Susie A. Jones | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 9-1-10-12

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-16-, 1949 *to* 11-12-, 1949 *that I last saw the deceased alive on* 11-11-, 1949 *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John E. J. Camper M. D. | 639 N. Carey St | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 11-17-49 | Mt. Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | James A. Hayes | 638 N. Gilmor St |

VS 150

463

G79824

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79824

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry J. Pfaff

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1116 Wilcox St.

c. Length of stay in Baltimore: 54 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1116 Wilcox St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | June 12, 1895 | 54 | 4 29 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Pfaff | Margaret C. Weiss |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | none | Mrs Barbara House |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Bladder

DUE TO

(B) Epithelioma of Scalp (melanoma) pigmented mole - primary site

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1948 | carcinoma - biopsy of glands & neck | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| M. | | |

22. *I hereby certify that I attended the deceased from* Feb 1948 *to* 11/10/1949, *that I last saw the deceased alive on* 11/10/1949, *and that death occurred at* 6:30 A. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. L. Hornstein M. D. | 204 E. Biddle St 2 | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-15-1949 | Holy Redeemer Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 14 1949 | Registrar for Maryland, Md. | Elmer W. Corkin 924 E. Eager St. |

VS 150

53

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79825

MS—132155

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79825

1. NAME OF DECEASED (Type or Print): Joseph Gayleard

2. DATE OF DEATH: 11-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 309 S. Parrish St. 19-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 30, 1888 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: D

14. MOTHER'S MAIDEN NAME: D

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|---|
| | | | Records—Baltimore City Hospitals. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis

DUE TO

(B) Carcinoma of the Lung

DUE TO

(C) Posterior Myocardial Infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 9-26- , 1949, *to* 11-12- , 1949, *that I last saw the deceased alive on* 11-12- 1949, *and that death occurred at* 12:05PM, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| R. S. Cooper M. D. | B.C.H.—4940 Eastern Ave. | 11-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-15-49 | Loudon Park | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams M.D. | Frederick A. Cole | 1913 W. Baltimore St. |

VS 150

47

G79826

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59 ✓ Registered No.

G79826

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SUSIE ELLEN HUNTER

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3900 Old York Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): 3900 Old York Rd. 9 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Oct. 16, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Martin Russell | Susie Keener |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT 3900 Old York Rd. ADDRESS 18 |
|---|---|---|
| no | none | Mr. Harry Hunter |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchio Pneumonia | 2d |
| DUE TO | Uraemic Coma | 5d. |
| ANTECEDENT CAUSES (B) | Arterio Sclerosis, Hypertension | 14 y |
| DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | Coronic Interstitial Nephritis | 14 y |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* Nov 11, 1949, *that I last saw the deceased alive on* Nov 11, 1949, *and that death occurred at* 9 30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. F. A. Stevens M. D. | 2878 Harford Rd | 11-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/14/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. | |

VS 150

131a

G79827

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79827

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Elizabeth Silcott

2. DATE OF DEATH: 11/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 2314 Old Frederick Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Dec. 11 1816 | 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas F. Hannon
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Thomas Silcott ADDRESS: 180 Osborne Ave Catonsville

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (a) | Acute congestive heart failure | 1 hr. |
| DUE TO (b) | Arteriosclerotic Hypertensive CVD | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Cerebral hemorrhage, rt c left hemiplegia | 13 days |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/29 1949 to 11/11 1949, that I last saw the deceased alive on 11/11 1949, and that death occurred at 9 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Robert G. Lucas M.D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 11/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-14-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George A. Farley
ADDRESS: Fulton and Fayette St.

VS 150

93D

Correct age if especially important. Physicians: please write the cause of death clearly and legibly.

G79828

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G79828

1. NAME OF DECEASED (Type or Print): MARY C. FLANAGAN

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 130 S. Loudon Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28
D. STREET ADDRESS (If rural, give location): 130 S. Loudon Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F E M | W | Married | Aug 13, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Luther Gelsricks | Rhinehart |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs. Blackburn | 3819 Dalfield Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculosis Pulmonary — INTERVAL BETWEEN ONSET AND DEATH: Many years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Nov 14, 1937 to Nov 12, 1949 that I last saw the deceased alive on Nov 10, 1949, and that death occurred at 5.01 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Elise Wadsworth M. D. | 343 N Broadway | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-14-49 | Balto. National | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | George A. Farley | Fulton Ave & Fayette St. |

VS 150

130

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79829
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E819.4 G79829
Registered No.

1. NAME OF DECEASED (Type or Print): Arthur Louis Lyon — N-856-2

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 2966 Cornwall Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | May 4, 1926 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Crane Operator | Bethlehem Steel | Baltimore, Md. | |

13. FATHER'S NAME: Arthur L. Lyon

14. MOTHER'S MAIDEN NAME: Ella M. Wooden

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | W. W. 2 | | Mrs. Doris Lyon | 2966 Cornwall Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cranio-cerebral injury | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): South on Dundalk Ave. below Bushy St. 26/5
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 12, 1949 1 A. M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Auto overturned and then into fixed objects

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: R.S. Fisher, M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: Nov. 12, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 14 1949 | Baltimore National | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Tunstall for Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Roland L. Fisher, 2112 Dundalk Ave.

VS 151

170c

G79830

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79830

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE F. MANSFIELD

2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General

C. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28 01
D. STREET ADDRESS (If rural, give location): 3715 Harmon Ave #7

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | 3/3/71 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer
10B. KIND OF BUSINESS OR INDUSTRY: Wholesale -
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm. Mansfield
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give date or dates of service):
16. SOCIAL SECURITY NO.: 265-40-7744
17. INFORMANT: Mrs. E. Harney ADDRESS: 3715 Harmon Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Obstructive Jaundice
DUE TO
(B) Ca of head of pancreas (?)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypostatic pneumonia

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/13 19 49 *to* 11/12 19 49 *that I last saw the deceased alive on* 11/12 19 49 *and that death occurred at* 1:35 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles J. Black M. D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 11/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 15 49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cem
24D. LOCATION (City, town, or county): Pikesville (State): Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellis Amorean ADDRESS: 4510 Liberty Hgts Ave

VS 150

469

G79831

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G79831 Registered No.

1. NAME OF DECEASED (Type or Print) George RAMANAUSKAS

2. DATE OF DEATH Nov 12-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3704. 3rd. ST

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 43 yr. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3704 3rd St. 25-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | ? 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | - | Lith. | yes |

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | - | Albert RAMANAUSKAS | 3704 3rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary occlusion

DUE TO

(B) hypertension cardio-vascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1949 *to* Nov 12, 1949 *that I last saw the deceased alive on* Nov 12, 1949 *and that death occurred at* 12 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip W Kristen M. D. | 302 Patapsco Ave | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov 15 1949 | Holy Cross Cem | Anundel County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Joseph KASINSKAS, Inc. | 602 Wood. Ave |

VS 150

93D

G79832

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

92.6 G79832 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Chandler — 17 - 0 Y

2. DATE OF DEATH: 11 - 12 - 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 550 Oakland St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) Md.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (write) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | B | Separated | Apr. 17 1909 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Culpepper Va | U. S. A. |

13. FATHER'S NAME: George Tulley

14. MOTHER'S MAIDEN NAME: Belle Parker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | George Tuley | 580 - Biddle |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Anemia | |
| DUE TO (B) | Sickle Cell Anemia | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-12-49 19__, *to* 11-12-49 19__, *that I last saw the deceased alive on* 11-12-49 19__, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fred R. Hahn M. D. | University Hosp | 11-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-17-49 | Mt. Calvary Cemetery | Cedar Hill Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | A. A. Halstead | 918 - Druid Hill ave. |

VS 150

730

G79833

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79833

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EUGENE CHANEY

2. DATE OF DEATH: Nov. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blackstone Apts. Charles & 33rd Sts.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): Blackstone Apts. Charles & 33rd Sts.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | July 7, 1866 | 83 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Physician (rtd) | | Bristol, Md. | |

13. FATHER'S NAME: Joseph Chaney

14. MOTHER'S MAIDEN NAME: Sarah Jane Drury

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Mrs. Susan Chaney - Blackstone Apts. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 48 hrs |
| DUE TO (B) | Generalized arteriosclerotic | 6 Yrs |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | Vascular disease, Chronic Myocarditis. | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 27, 1949, *to* November 13, 1949, *that I last saw the deceased alive on* Nov 13, 1949, *and that death occurred at* 7:30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Newland Edward Day M. D. | 4-E-33rd St - 18 | November 14, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | St. James Cem., | Lothian, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Tuntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92D

G79834

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79834

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY EDITH BOWERS

2. DATE OF DEATH: 11-13-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Govans Park
D. STREET ADDRESS (If rural, give location): 1601 St. Agnes Lane #7.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | M. | 6-8-1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | home | PA. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Columbus Doran | Huldah McCollough |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Cecil D. Bowers | 1601 St. Agnes La. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE CORONARY OCCLUSION

DUE TO

(B) HYPERTENSIVE CARDIO-VASCULAR DISEASE

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/11, 1949 *to* 11/13, 1949 *that I last saw the deceased alive on* 11/13, 1949, *and that death occurred at* 1:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John R. Lord M.D. | St. Agnes Hosp. | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

G79835

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17° Registered No. G79835

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Anna Glenn

2. DATE OF DEATH: Nov 13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4217 Shamrock Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4217 Shamrock Ave 76 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Jan 31 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Baltimore | |

13. FATHER'S NAME: Andrew Heselbach

14. MOTHER'S MAIDEN NAME: Annie M Voglesong

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: William M Glenn ADDRESS: 4217 Shamrock Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ascending Pulmonary Oedema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(B) Carcinoma of Breast & Lungs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* [illegible], to 11/13, 1949 *that I last saw the deceased alive on* 11/13, 1949 *and that death occurred at* 9:55 *from the causes and on the date stated above.*

23A. SIGNATURE: Arnold J. Kaskas 23B. ADDRESS: 3323 E. Baltimore St 23C. DATE SIGNED:

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17 49 | Parkwood | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wilhelm Funeral Home ADDRESS: 2018 Orleans

VS 150

50

G79836

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79836

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William A Durkin

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 407 Augusta St

c. Length of stay in Baltimore: Yrs. 5 Mos. - Days 01

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 407 Augusta St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Widower | Dec. 26, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Durkin | Annie ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 215-05-0516 | Flora Ahrens | 413 E 24th St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiorenal disease — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO

(B) arteriosclerosis

DUE TO

(C) senile changes.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 4, 1949 *to* Nov 11, 1949 *that I last saw the deceased alive on* 11 Nov, 1949 *and that death occurred at* 6:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas. E. Boswell M. D. | 121 Augusta St | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 15/49 | Mt. Calvary Cem. | A.A. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Livingston Williams, M.D. | Wm. Robert A Elliott & Daughter | 1210 8129 N. Carlton St. |

VS 150

G79837

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E98.6 G79837 Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): Charles Smith — N-879

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1316 N. Central Ave. T-09

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

3C. Length of stay in Baltimore — Yrs. Mos. Days:

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | C | Divorced | Feb 3 1916 | 33 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Longshoreman | Local 921 | N.C. | |

13. FATHER'S NAME: Joseph Perry

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Irvin Rozier - 913 Ernest St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Exsanguination

DUE TO

ANTECEDENT CAUSES

(B) Stab wound, left femoral artery

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Restaurant

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1231 E. Biddle St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 11, 1949 7:35 P.M.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Sharp instrument

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty, M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Nov. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 11/14/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State): Fayetteville N.C.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949

REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Mrs Robert G. Elliott, Daughter 1129 N Caroline St.

167

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 143

Registered No. G79838

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN DAUGHERTY

2. DATE OF DEATH: November 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: D.C. (District of Columbia) (djm)
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 232 W Street, N. W.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | | 2-9-1894 | 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Elevator Operator | Elevator operator | Washington D.C. | U.S. |

13. FATHER'S NAME: John Thomas Daugherty

14. MOTHER'S MAIDEN NAME: Ella Louise Blackston

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | World War I | | William Daugherty | 232 W. St. N.W. Washington |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio vascular Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: W. J. McClafferty M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 11-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 11/14/49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State): Washington, D.C.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wilson & Schug Inc

ADDRESS: Wash. D.C.

VS 151

937

G79839

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79839

BIRTH NO. 1 Registered No. 331

1. NAME OF DECEASED (Type or Print): SARAH MINDEL

2. DATE OF DEATH: 11-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Feinblatt Home
C. Length of stay in Baltimore: Yrs. 50 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3600 Edgewood Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 87 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lith
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Meyer Mindel ADDRESS: 3600 Edgewood Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 wks.
DUE TO
(B) ARTERIOSCLEROSIS — 10 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 8 1949 *to* Nov. 14, 1949 *that I last saw the deceased alive on* Nov. 13 1949, *and that death occurred at* 3:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Colbert Hunsefarb M. D.
23B. ADDRESS: 1801 Eutaw Pl
23C. DATE SIGNED: Nov. 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/14/49
24C. NAME OF CEMETERY OR CREMATORY: Beth Hebrew
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl.

VS 150

83a

G79840

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

433 1 G79840

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henrietta Mosley 443

2. DATE OF DEATH: Nov 11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 147 East St.

C. Length of stay in Baltimore: 20 — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 147 East St 5-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | W | Oct. 27-1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Tarboro N. C. | U. S. A. |

13. FATHER'S NAME: Henry White

14. MOTHER'S MAIDEN NAME: Hannell Cobb

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs E. Mosley — ADDRESS: 151 East St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fibrillation of heart — INTERVAL BETWEEN ONSET AND DEATH: 19 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Congestive heart failure — ?

DUE TO

(C) Hypertension — ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic ulcer of leg

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 27, 1949, *to* Nov. 11, 1949 *that I last saw the deceased alive on* Nov. 1, 1949, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. W. McDaniel, M. D. | 812 N. Carrollton St | Nov. 14, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 11-15-49 | Mt. Calvary | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Byron & Mamie W. Wright | 1531 721 Augusta St |

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G79841

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

33 ✓ G79841 Registered No.

1. NAME OF DECEASED (Type or Print): William Valentine

2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
C. Length of stay in Baltimore: 40 Yrs. / Mon. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 13-01
D. STREET ADDRESS (If rural, give location): 2514 Brookfield Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C. | S | 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | Private | Loudon Co. Va. | U. S. A. |

13. FATHER'S NAME: George Valentine
14. MOTHER'S MAIDEN NAME: Sarah Blue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Ada Wilkins ADDRESS: 1605 Lanvale St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypostatic pneumonia
DUE TO
(B) Cereb-al thrombosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-7, 1949, to 11-12, 1949 that I last saw the deceased alive on 11-12, 1949 and that death occurred at 6 [illegible] m., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: Nov. 13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 11-15-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. — Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Lurtington Williams, M.D.
25. FUNERAL DIRECTOR: Samuel W. Sullivan Jr. ADDRESS: 82R 1011 W. Arlington Ave

VS 150

G79842

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79842

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Spriggs

2. DATE OF DEATH: November 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 419 Heaver Street (Heaper)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 4-12-1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Trash truck | Baltimore, Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Spriggs | Ella |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Sarah Spriggs | 419 Heaper St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Latent lues

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| Emil L Hayer | | | 13 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Bu | 11-16-49 | Mt. Calvary | A.A. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Samuel W. Sulkowski Jr. | 1011 N. Arlington Ave |

VS 151

309

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79843

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79843

Registered No.

1. NAME OF DECEASED (Type or Print): Charles A. Nelson

2. DATE OF DEATH: Nov-12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3503 Liberty Heights Ave

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 - 38
D. STREET ADDRESS (If rural, give location): 3503 Liberty Heights Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | NOV-8-1878 | 71 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Balto. Gas-Light Co | Baltimore Md. | USA. |

13. FATHER'S NAME: Benjamin L. Nelson

14. MOTHER'S MAIDEN NAME: Alice Boyd

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 213-03-8693 | J. A. Nelson | 227 St. Paul St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

(B) Arteriosclerotic Cardiovascular Disease — 10 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Jan 10, 1943 to Nov. 13, 1949 that I last saw the deceased alive on Nov. 12, 1949 and that death occurred at 2 a. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. L. Lemmon M. D. M. D. | 11 E. Chase St. | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 14/49 | Mt. Olivet Cem. | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | E. B. Lippert & Son | 1300 Eutaw Pl. |

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G79844

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G79844 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John CHANEY
2. DATE OF DEATH: Nov 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 400 Gold St.
C. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 400 Gold St. 14-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | Jan 15, 1880 | 69 - 0 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Maryland | U.S.A. |

13. FATHER'S NAME: Frank Chaney
14. MOTHER'S MAIDEN NAME: Louise Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Lizzie Chaney
ADDRESS: 400 Gold St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardio-Vascular — Several

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: William J. Helbrech M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 11/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov-16 '49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mr. Frances G. Hemsley
ADDRESS: 578 W. Biddle

VS 151

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 11-16-49

Dr. Kerfin

CERTIFICATE CORRECTED 11-25-49

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163

Registered No. G79835

1. NAME OF DECEASED (Type or Print): Garland Robert G. Poole

2. DATE OF DEATH: Nov. 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3506 Parkside Drive

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3506 Parkside Drive 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 11, 1898 ~~1868~~ | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Electrician | | Crew, Virginia | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 215-07-0884

17. INFORMANT: Mrs. Margaret . Poole, 3506 Parkside drive ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 hrs

DUE TO

(B) Tuberculosis of Lung Rt — ~~2-7-49~~ Sept. 1949

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 10/10 ~~11-11-49~~ | Ca of Lung - Malignant | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 19 49 *to* Nov 13 19 49, *that I last saw the deceased alive on* Nov 13 19 49 *and that death occurred at* 1:25 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter T. Kerfin M. D. | 4351 Harford Rd | Nov 13 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-16-49 | Moreland Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Leonard J. Ruck, 5305 Harford Road. |

VS 150

477

CERTIFICATE CORRECTED 11-15-49

G79846

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79846 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lorin A. Niles

2. DATE OF DEATH: Nov 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5607 Fair Oaks Ave
C. Length of stay in Baltimore: Yrs. 37 Mos. 7 Days 06

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5607 Fair Oaks Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | married | Apr. 19-1898 | 51 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Owner Optical Co. | | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William A. Niles | S. Roberta Walker |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Marie E. Niles | 5607 Fair Oaks |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| William G. Pelfrich M.D. | | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-17-49 | Oaklawn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Leonard Ruck | 5305 Harford Rd. |

VS 151

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79847 ✓ G79847

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

3 3 ✓ Registered No.

BIRTH NO. Moxley

1. NAME OF DECEASED (Type or Print) Mopley, Harry E

2. DATE OF DEATH 11-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-35
D. STREET ADDRESS (If rural, give location) 2060 E Belvedere Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug 21-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Gulette Co. | Balto Md. | |

13. FATHER'S NAME James A. Mopley

14. MOTHER'S MAIDEN NAME Mamie M. Lickards

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Lillian Mopley ADDRESS 2060 E. Belvedere

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Thrombosis, brain stem | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Pneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-8, 1949 *to* 11-13, 1949, *that I last saw the deceased alive on* 11-13-49, 19__, *and that death occurred at* 1:8 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Nichols Jr. M. D. | University Hospital | 11-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-16-49 | Lockwood | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Leonard J. Luck | 5305 Harford Rd. |

VS 150

8 2 B

G79848

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79848

BIRTH NO. 49-24309

1. NAME OF DECEASED (Type or Print): BABY BOY DAVIS

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTIMORE GENERAL HOSP
c. Length of stay in Baltimore 8 Hours 47 Min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltim
B. COUNTY: Wa Baltim General
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-10
D. STREET ADDRESS (If rural, give location): Reynar & Fruckland St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M. | W | Single | Nov. 12, 1949 | | | 8 47 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltim | U.S.A. |

13. FATHER'S NAME: Norman E Davis

14. MOTHER'S MAIDEN NAME: Emma Bosson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Emma M. Bosson | 716 Lexington St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis, Pulmonis — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 12 1949 *to* Nov. 12, 1949 *that I last saw the deceased alive on* Nov. 12, 1949, *and that death occurred at* 10 55 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Daniel Silverstein M. D. | West Balto Gen. Hosp. | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 14 1949 | New Cathedral Gen | Old Frederick Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | John C. Horan | 3000 E. Baltimore St |

VS 150

159

G79849

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450.1

G79849

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frederick W. Zuelke

2. DATE OF DEATH: Nov. 12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1626 Cereal St.

c. Length of stay in Baltimore: 55 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1626 Cereal St. 25-05

5. SEX: Male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Dec. 2-1866
9. AGE (In years last birthday): 83 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shoe Maker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ferdinand Zuelke
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Edna M. Zuelke ADDRESS: 1626 Cereal St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. it means the disease, injury or complication which caused death.)

(A) Cerebral Sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) generalized arterio-sclerosis (1) begin

DUE TO

(C) gangrene of left foot

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Bilateral inguinal hernia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Samuel Perkins M. D.
23B. ADDRESS: 203 Valentine ave
23C. DATE SIGNED: 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-15-1949
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Deputy for Williams, M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

VS 150

122a

679850

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679850

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Benjamin Heavner

2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: [redacted] West Virginia
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): [redacted] Clarksburg
D. STREET ADDRESS (If rural, give location): 227 Rose Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 2/17/1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Work
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): W. Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Urinary retention — 5 days
DUE TO
Benign Prostatic Hypertrophy — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/9, 1949 *to* 11/12, 1949, *that I last saw the deceased alive on* 11/12, 1949, *and that death occurred at* 9:55A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marion C. Dunlap M. D. | 1213 Light St Balto Md | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| removal | 11/14/49 | Clarksburg | Clarksburg, West Virginia |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Wm. Cook, Inc., 1217 St. Paul Street — ADDRESS

VS 150

137a

G79851

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79851

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert Sidney Ranlett

2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 339 E. 25th Street

c. Length of stay in Baltimore: About 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 339 E. 25th St. 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Divorced | 5/21/92 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Sears Roebuck Co. | New Orleans, Louisiana | |

13. FATHER'S NAME: Albert Sidney Ranlett

14. MOTHER'S MAIDEN NAME: Cora Semmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — ADDRESS: Mrs. Geo. Kantzler 530 Park Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteio-Sclerosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) ..... DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* [Autopsy, Inspection or Inquiry] *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L. Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 13 NOV 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | | New Orleans, Louisiana |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | Hendley W. Meares and Son | 505 N. Calvert |

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AB-133292
G798.2

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

776 G798.2

Registered No.

BIRTH NO. 49-25240

1. NAME OF DECEASED (Type or Print): Baby Boy Dorsey

2. DATE OF DEATH: 11-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1124 Calhoun St. 16 ward

5. SEX: M
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 8-1949
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours 1 / Min. 25
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Melvyn Dorsey
14. MOTHER'S MAIDEN NAME: Emma Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8- , 19 49 *to* 11-8- , 19 49 *that I last saw the deceased alive on* 11-8- , 19 49 *and that death occurred at* 7.25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 11-10-49 @ 9:00 AM
24C. NAME OF CEMETERY OR CREMATORY: Baltimore City Hospitals 4940 Eastern Ave.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 14 1949
REGISTRAR'S SIGNATURE: [signature] for Nathanson, M.D.
25. FUNERAL DIRECTOR: ADDRESS:

VS 150

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G79853

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

170

Registered No. G79853

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DOROTHY J. O'GRADY

2. DATE OF DEATH NOV. 14, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 2404 MONTICELLO Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE MD.

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-09

D. STREET ADDRESS (If rural, give location) 2404 MONTICELLO RD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | OCT. 31 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | REAL ESTATE | NEW YORK, N.Y. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| BENJAMIN F. MILLER | EDWINA ROBERTS |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | LEO MILLER | 2404 MONTICELLO R |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Lung Adeno Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 1 yr

DUE TO

(B) Adeno Carcinoma Left Lung

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 25 19 49 *to* Nov 14 19 49, *that I last saw the deceased alive* Nov 13, 19 49, *and that death occurred at* 9:45 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel H Cohn M. D. | 3611 Fowlers Rd | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-16-49 | HILLSIDE CEM. | PLAINFIELD, N.J. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | [illegible] Washington Boulevard, Md. | Charles L. Zeiler | 901 S Conkling St. |

VS 150

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C798:54

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C798:54

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VIRGIE MAY SPRIGLE

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1822 Moreland Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1822 Moreland Ave. 15 03

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | married | July 30, 1891 | 58 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Carroll Co., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Gardner | Mary Cox |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Arthur E. Sprigle | 1822 Moreland Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia

DUE TO

(B) Acute Coma

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 8 yr. 6 Day

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/5/49, 19__, *to* 11/11/49, 19__, *that I last saw the deceased alive on* 11/11/49, 19__, *and that death occurred at* 8 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry C. Hounds M.D. | 4 W. Mulberry | 11/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/14/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 14 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

61

G79855

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79855 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH T. BARROW, SR.

2. DATE OF DEATH: NOV 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3524 LYNDALE AVE
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3524 LYNDALE AVE. E-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE. | MARRIED | OCT 28 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ASSEMBLY LINE | GLENN L. MARTIN | MARYLAND | U.S. |

13. FATHER'S NAME: JOSEPH B. BARROW

14. MOTHER'S MAIDEN NAME: THERESA HOFFNAGLE.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: MRS. RITA M. BARROW - ADDRESS: 3524 LYNDALE AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Valvular heart disease | yrs |
| DUE TO (B) | Rheumatic fever (org) | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

grave infection at time of death?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* NOV 12, 1949 *that I last saw the deceased alive on* NOV 11, 1949, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm D. McFaul Jr. M.D. | 840 W. 36th St 11 | 11/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV 15 1949 | NEW CATHEDRAL | OLD FREDERICK-RD MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams M.D. | Eustin B. Donovan | 3818 Roland Ave |

VS 150
NOV 14 1949

92c

G798:56

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

170 Registered No. G798:56

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna M. Reed

2. DATE OF DEATH: Nov. 12 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3520 Hilton Rd. Ashburton House

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 30 E. Henrietta St. 2-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Jan. 12, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Telephone operator | Balto. City | Balto. Md. | |

13. FATHER'S NAME: George W. Reed

14. MOTHER'S MAIDEN NAME: Ella Finn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | none | Mrs. Ella Reed | 30 E. Henrietta St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast, left — INTERVAL BETWEEN ONSET AND DEATH: 3½ years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 4 1946 | Carcinoma of breast, left | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from June 4, 1946, to Nov 12, 1949, that I last saw the deceased alive on Nov. 12, 1949, and that death occurred at 7 A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William E Johnson M. D. | 100 E. 33rd St. | Nov 14 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 15/49 | New Cathedral | Old Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | KRAUSE FUNERAL HOME | 12163 Charles |

VS 150

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G79857

BIRTH NO. 131197

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.0 Registered No. G79857

1. NAME OF DECEASED (Type or Print): Henry Zick

2. DATE OF DEATH: 11-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5 W. 24th Street 1206

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Aug. 11, 1875
9. AGE (In years last birthday): 74 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (D) Henry Zick
14. MOTHER'S MAIDEN NAME: (D) Charlotte Bohrer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: RECORDS* BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart Disease | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-19, 19 49 *to* 11-11, 19 49 *that I last saw the deceased alive on* 11-11 1949, *and that death occurred at* 12:20 m A *from the causes and on the date stated above.*

23A. SIGNATURE: A. S. Rogers M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 11-14-49

24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify): Burial
24B. DATE: 11/16/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Western
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949
REGISTRAR'S SIGNATURE: Turrington Williams, M.D.
25 FUNERAL DIRECTOR: [illegible] ADDRESS: [illegible] St. Paul St.

VS 150

93D

679858

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

679858

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Charles A. P. Campbell

2. DATE OF DEATH: 11/10/49 6 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1441 N. Bond St
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1441 N. Bond St. 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 8/31/1861 | 88 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Car Inspector
10B. KIND OF BUSINESS OR INDUSTRY: Pa. R.R.
11. BIRTHPLACE (State or foreign country): Gettysburg Pa.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: (Unknown) Campbell
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Ft. Smallwood Rd Emma C. Algere a. a. Co. Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-vascular disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1, 1940 to Nov. 12, 1949, that I last saw the deceased alive on Nov. 10, 49 and that death occurred at 6 00 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Edward A. Mills M. D. | 23B. ADDRESS: 1331 E. Monument Ave | 23C. DATE SIGNED: 11-14-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 11/16/49 | 24C. NAME OF CEMETERY OR CREMATORY: Balto. | 24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Wm Cook Inc. | ADDRESS: 127 St. Paul st.

VS 150

937

G79859

MS—133412

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Apr. 1

G79859 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Brown

2. DATE OF DEATH 11-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. Life — Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 3017 Windsor Ave. 11-5-47

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 12-18-1878 | 70 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gardener
10B. KIND OF BUSINESS OR INDUSTRY Gas - Blackwell St.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John W. Brown
14. MOTHER'S MAIDEN NAME Matilda R. Hammond
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 248-10-2207
17. INFORMANT ADDRESS Baltimore City Hospitals Records—4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized arteriosclerosis | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Adeno-carcinoma of the rectosigmoid junction | |

19A. DATE OF OPERATION 11-13-49
19B. MAJOR FINDINGS OF OPERATION Int. Obstruction
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-13- , 1949, *to* 11-14- , 1949 *that I last saw the deceased alive on* 11-14- , 1949, *and that death occurred at* 10:10 AM *from the causes and on the date stated above.*

23A. SIGNATURE T. J. Regan M.D.
23B. ADDRESS B.C.H.—4940 Eastern Ave.
23C. DATE SIGNED 11-14-49

24A. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) Burial
24B. DATE 11/17/49
24C. NAME OF CEMETERY OR ~~CREMATORY~~ W. Oliver
24D. LOCATION (City, town, or county) Balto. Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 N. Penal St.

VS 150

467

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79880

BIRTH NO. 19860

1. NAME OF DECEASED (Type or Print): CATHERINE (KATE) C. SMOOT

2. DATE OF DEATH: Nov. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N. 504 Loudon Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 504 N. Loudon Ave. 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | March 23, 1861 | 88 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Ireland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick Boughen | Ann C. Coughlin |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Mary E. Johnson, 504 N. Loudon Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | General debility — | |
| DUE TO (B) | Arteriosclerosis. | 10 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* Nov 14, 1949, *that I last saw the deceased alive on* Nov. 12, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thos. Cell Wells, M. D. | 4100 Edmondson Ave. | Nov. 14, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

97

G78861 X ✓ 570.5 G78861

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS. CATHERINE PORTER
2. DATE OF DEATH 11/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSP.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20 Md. Middle River
D. STREET ADDRESS (If rural, give location) ROUTE 14 BOX 160

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | 3/2/72 | 77 | 8 | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Balto County, Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Winkler | Josephine Luke |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Raymond Parter | Rt. 14 Box 33 Balto. 20 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) INTESTINAL OBSTRUCTION (PARTIAL)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) ETio. Unknown
DUE TO

(C) CARDIAC FAILURE
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic C-V-D.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/8 1949, to 11/13 1949, *that I last saw the deceased alive on* 11/13 1949, *and that death occurred at* 8:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William S. Womack M. D. | Bon Secours Hosp. | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/17/49 | Moreland Memorial Park | Taylor Ave. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Lasasha Funeral Home | 7401 Belair Rd. |

VS 150

93D

079862

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 079862

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HOLLAND, JOSEPHINE

2. DATE OF DEATH: 11/12/49 2:30 AM

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 914 Franklin. 1801

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp 1514 Dru...

c. Length of stay in Baltimore: Yrs. Mos. Days: life

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Widowed | 1864 | 85 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Housewife, retired): School Teacher
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. City
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John R. Scott
14. MOTHER'S MAIDEN NAME: Sarah Hughes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Josephine Bussey ADDRESS: 2303 Round Hill Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) arteriosclerotic heart disease.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/1 19 49 *to* 11/12 19 49 *that I last saw the deceased alive on* 11/11 19 49 *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: John R. Holmes M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 11/14

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: NOV 15 1949
24C. NAME OF CEMETERY OR CREMATORY: Arbutus Memorial Park
24D. LOCATION (City, town, or county) (State): Arbutus Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Robert J. Williams
ADDRESS: 1515 N. Eden St

VS 150

93D

G78863 9697

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G78863 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Patty Bell Stewart

2. DATE OF DEATH 11-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 234 Silver Ct.

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | Oct. 1, 1921 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | North Carolina | |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| William Jamison | Charlotte Jefferson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT'S ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records-- 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5-13- , 1948, *to* 11-12- , 1949, *that I last saw the deceased alive on* 11-12- , 1949, *and that death occurred at* 2:40PM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Cozen M.D. | B.C.H.--4940 Eastern Ave. | 11-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/15/49 | | Semora, N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Joseph S. Rocks Jr. | 1304 N. Central Ave |

VS 150

136

FS-183406

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79864

DEATH NO. H-85568

1. NAME OF DECEASED (Type or Print): Ronald Barnes

2. DATE OF DEATH: 11-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1232 N. Eden Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | Aug. 7, 1947 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Emburas Barnes, Jr.

14. MOTHER'S MAIDEN NAME: Helen Brue

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | RECORDS* BALTO. CITY HOSPITALS | 4940 EASTERN AVE |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pneumococcic Meningitis. | |
| DUE TO | (B) Pneumonia. | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-12 1949 *to* 11-13 1949 *that I last saw the deceased alive on* 11-13 1949 *and that death occurred at* 6:50 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Avenue | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Mt. Calvary | [illegible] County, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Joseph E. Brooks, Jr. | 1307 N. Eden St. |

VS 150

810a

G79865

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79865 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT LOUIS FORD

2. DATE OF DEATH Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ohio
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Toledo
D. STREET ADDRESS (If rural, give location) 723 Summit St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 4/2/93 | 56 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | Seafarer | Minn. | USA |

13. FATHER'S NAME Anthony Ford

14. MOTHER'S MAIDEN NAME Laure ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | Unknown | Records- US Marine Hospital, Balto, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia, lobular, rt. lung | Duration 1-2 wks. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Carcinoma, squamous cell, rt. tonsillar area of mouth | Duration- more than 10 mo. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 11 1949 *to* Nov. 6 1949, *that I last saw the deceased alive on* Nov. 6 1949, *and that death occurred at* 4:22P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. L. Wilson Clin. Director J. L. Wilson, Medical Director | US Marine Hospital, Balto, Md. | 11/ /49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/15/49 | St. Peter's Cemetery | Baltimore - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 15 1949 | Emily Jo Williams, M.D. | Earl B. Wolverton 403 E. 25th St. Baltimore-18 |

VS 150

45C

66 X ✓ 66

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

16 ✓ Registered No. 779868

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BENIGNO CARRIDO

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: California
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Francisco
D. STREET ADDRESS (If rural, give location): 1265 Stockton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 9/9/97 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| FWT | Seaman | Spain | |

13. FATHER'S NAME: Ramon Garrido

14. MOTHER'S MAIDEN NAME: Carmen Garcia

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | 552-22-5328 | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiectasis and lobular pneumonia right lower lobe due to — Interval between onset and death: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Obstruction of right lower lobe bronchus by carcinoma of lung — Interval between onset and death: Unknown

DUE TO (C) Metastasis to liver and adrenals — Interval between onset and death: Unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct. 6, 1949 *to* Nov. 9, 1949 *that I last saw the deceased alive on* Nov. 9, 1949 *and that death occurred at* 6:30A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/ | St Peter's | Baltimore — Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Earl B. Wheeler | 403-6-25th St Baltimore-18-Md |

VS 150

49D

G79867

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G79867

1. NAME OF DECEASED (Type or Print): Bessie Shapiro

2. DATE OF DEATH: Nov. 14 /49

3. PLACE OF DEATH: Baltimore City, Maryland — 3706 Nortonia Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2702 Violet Ave.

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

c. Length of stay in Baltimore: 40yrs. (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | I887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Russia | |

13. FATHER'S NAME: Emanuel Zuriff

14. MOTHER'S MAIDEN NAME: Unknow

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | HermanL. Gildin | 802 Chauncey Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Uremic Poisoning | 14 days. |
| DUE TO | Arteriosclerosis & Nephritis. | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| (B) | Cerebral Hemorrhage | 2 wks. |
| DUE TO | Hypertension | years. |
| (C) | Deabetes | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb, 1949, *to* Nov 14, 1949, *that I last saw the deceased alive on* Nov 14, 1949, *and that death occurred at* 10.10 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rector M. Kolker M. D. | 3700 Park Heights ave. | Nov 14 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 15, 1949 | Adas Israel Beth Isaac Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

61

G79868

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79868

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Charles Sodie

2. DATE OF DEATH 11-14-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2135 No Fulton Ave

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 38 Yrs. Mos. Days

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH ?
9. AGE (In years last birthday) 64 Under 1 Year: Months Days; Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME Samuel
14. MOTHER'S MAIDEN NAME Hannah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Bertha Sodie ADDRESS 2135 N Fulton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Squamous cell Carcinoma of lung

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Cardiac Failure - Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 11-11-49
19B. MAJOR FINDINGS OF OPERATION Carcinoma of Lung & Metastases
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-13 *19*49 *to* 11-14 *, 19*49*, that I last saw the deceased alive on* 11-14 *, 19*49*, and that death occurred at* 1:50 pm*., from the causes and on the date stated above.*

23A. SIGNATURE Harold Cramer, M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 11-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11-15-49
24C. NAME OF CEMETERY OR CREMATORY Rosedale
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR NOV 15 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eastern Ave

VS 150

477

G73869

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54.0

G73869 Registered No.

BIRTH NO. H-82523

1. NAME OF DECEASED (Type or Print) Merrick Cohen 520777

2. DATE OF DEATH NOV 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5111 Arbutus Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | 6-26-47 | 2 4/12 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Baltimore Md | |

13. FATHER'S NAME Aaron Cohen

14. MOTHER'S MAIDEN NAME Freida Cramer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

DUE TO

(B) Tetralogy of Fallot Congenital

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-12 1949 *to* 11-14 1949 *that I last saw the deceased alive on* 11-14 1949 *and that death occurred at* 1045 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard V. Ruffin, Jr. M. D. | JOHNS HOPKINS HOSPITAL | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-15-49 | Hebrew Young Men | Pikesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

157E

G79870

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44r

G79870 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) DEMARIS HATTON

2. DATE OF DEATH Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 516 W. Preston Street
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 516 W. Preston Street 17-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | ? | 66 - | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Winston-Salem, N.C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | George Hatton 516 W. Preston Street |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | hypertensive cardio-renal disease | six yrs. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | | |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | mitral insufficiency | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1-7, 1949 *to* 11-12, 1949 *that I last saw the deceased alive on* 11-10, 1949 *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

SAYLES BROWNE, M.D.
1 EAST MADISON ST.
BALTIMORE, MD.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| | | 11.12.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 15, 1949 | Mt. Auburn | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | J. L. Preston Linberry 1631 Druid Hill Ave. |

VS 150

131a

79871

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79871

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Buren
(b) Street address 801 Baren St.
(c) Hospital or institution:
Balto. City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 Pacific St 1205 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD Frank PENN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1949 [illegible]

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Plumbers Helper

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address Isabell Nordes 726 Pacific St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/49 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Raleigh Ave

18 (a) Funeral director Paul E. L. Kenworthy Jr.
(b) Address 2615 Lakeside Ave.

19 (c) NOV 15 1949 (Date rec'd by registrar) Registrar Huntington Williams M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH November 14/49 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1949 to 11/14 1949, and that I last saw him alive on 11/13 1949.

Immediate cause of death: Coronary occlusion — Duration: [illegible]

Due to: Hypertensive cardio vascular disease — Duration: Unknown

Due to: — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Marmorstein M. D.
Address 801 Buren St Date signed 11/14/49

VS 150

937

G79872

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153 Registered No. G79872

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jennie E.Kennedy

2. DATE OF DEATH: Nov.13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1611 Dundalk Avenue none

C. Length of stay in Baltimore: 25yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 1611 Dundalk Ave.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1611 Dundalk Ave. 26 06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 6,1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fuel Line Assembler | Eastern Aircraft | Harrisburg Pa. | |

13. FATHER'S NAME: Wm. Davis

14. MOTHER'S MAIDEN NAME: Maud Bishop

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| --- | --- | 214-01-3397 | Mr. Louis E. Kennedy | 1611 Dundalk Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF THE SIGMOID — INTERVAL BETWEEN ONSET AND DEATH: 18 Mo

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| APRIL 1949 | Carcinoma of Sigmoid & Met for Ovaries | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 1949 *to* November 1949 *that I last saw the deceased alive on* November 13 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Stephen C. Mackowiak M. D. | 6714 Holabird Ave | Nov 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov.16/49 | Greenmount Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Thurlington Williams, M.D. | [illegible] | 2024 Orleans St |

VS 150

46E

G79873

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79873

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN PAUL

2. DATE OF DEATH 11/13/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21
D. STREET ADDRESS (If rural, give location) 913 S. Highland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. JOSEPH'S 40 & P.

c. Length of stay in Baltimore ABOUT 64 YRS (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | NOV. 3, 1865 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED | BLACK-SMITH | FRANKFORT, GERMANY | U. S. A. |

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOSEPH PAUL ADDRESS: 704 N. CURLEY ST.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Arteriosclerotic cardio-vascular disease

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 10/25/49 19__, to 11/13/49 19__, that I last saw the deceased alive on 11/13, 1949, and that death occurred at 9:30 P m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Sawinski M. D. | St. Joseph's Hosp. | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-16-49 | SACRED HEART CEM | GERMAN HILL RD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Charles S. Feiler | 901 S. Conkling St. |

VS 150

92D

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

74 — 443 — Registered No. C79674 — 74

STATE NO.

1. NAME OF DECEASED (Type or Print): MARY R. GOLDSBOROUGH

2. DATE OF DEATH: Nov. 13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3431 Parklawn Ave.
c. Length of stay in Baltimore: 60 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8 01
D. STREET ADDRESS (If rural, give location): 3431 Parklawn Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | White | widowed | Sept. 2-1867 | 82 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Queen Anne Co. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Grayson Hobbs
14. MOTHER'S MAIDEN NAME: Mary Lesby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Nellie R. Stinson — ADDRESS: 3431 Parklawn

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Broncho-pneumonia | 3 days |
| DUE TO | | |
| (B) | Acute Cholecystitis | 3 wks |
| DUE TO | | |
| (C) | Cardio-vascular-hypertension disease | 5 yrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* Nov. 5 1949 to Nov. 13, 1949 *that I last saw the deceased alive on* Nov. 13, 1949 *and that death occurred at* 12 15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Homer L. Dodd M. D.
23B. ADDRESS: 2108 St Paul St
23C. DATE SIGNED: 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 16-49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Memorial Pk.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. J. Ness & Son — ADDRESS: 300 Reisterstown

VS 150

937

C79875

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

434.1 Registered No. C79875

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LANCELOT J. KELLETT

2. DATE OF DEATH: November 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1835 East Baltimore Street 2 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Feb 4 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Station Engineer | Rubber Co. | England | U.S.A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ------ | 232-18-3197 | Jacquiline Kellett | 1835 E Balto St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Chronic Passive Congestion

DUE TO

(C) Ascites -

(over)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/9, 1949 *to* 11/17, 1949, *that I last saw the deceased alive on* 11/17, 1949, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis Hyman M.D. | 2730 N Charles St | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17 1949 | Mt Carmel Cemetery | 1112 S Bonsel Street Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams M.D. | Doffel Bros. | 1800 E Lombard ST |

VS 150

93E

G79878

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17 Registered No. G79878

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arthur H. Becker

2. DATE OF DEATH: Nov. 13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3024 Windsor Nursing Homes

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto
D. STREET ADDRESS (If rural, give location): 2628 E Monument St 7-07

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 3 1875
9. AGE (In years last birthday): 74 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B.O. Grain Elev.
10B. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Becker
14. MOTHER'S MAIDEN NAME: Henerotta ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Elizabeth A. Becker ADDRESS: 2628 Monument St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Prostate
DUE TO
(B) with metastases
DUE TO
to bone.
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1949 *to* Nov 13, 1949, *that I last saw the deceased alive on* Nov 13, 1949, *and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: T. Paul Brady M.D.
23B. ADDRESS: 3033 W Mont St
23C. DATE SIGNED: 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 16-49
24C NAME OF CEMETERY OR CREMATORY: Western Cem.
24D LOCATION (City, town, or county) (State): Edmondson Ave Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Lippel Bro. ADDRESS: 1800 E Lombard St

VS 150

51 C

G79877

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

G79877 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs Mary E. Keyes

2. DATE OF DEATH: 11/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): ~~2408 Lake Ave~~

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)

8. DATE OF BIRTH: 8/28/88

9. AGE (In years last birthday): 61 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife - Jail

10B. KIND OF BUSINESS OR INDUSTRY: matron

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Eyrne

14. MOTHER'S MAIDEN NAME: Mary Roche

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Fr. Keyes ADDRESS: 1220 E. Layfayette

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/30, 19 49 *to* 11/12, 19 49 *that I last saw the deceased alive on* 11/12, 19 49 *and that death occurred at* ? *m., from the causes and on the date stated above.*

23A. SIGNATURE: Am Powell, Jr. M. D.

23B. ADDRESS: Mercy Hosp

23C. DATE SIGNED: 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 16 1949

24C. NAME OF CEMETERY OR CREMATORY: Cathedral

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Rita Wiedefeld ADDRESS: 900 E. Biddle St.

VS 150

8 3a

BIRTH NO. 79878

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

49 V. G79878 Registered No.

1. NAME OF DECEASED (Type or Print) ONA M. SIJAVIČIENE (ANNA SAVAGE) — 2. DATE OF DEATH 11-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1245 James St.

C. Length of stay in Baltimore 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1245 James St. 21-07

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W | Widowed | Dec 15, 1883 | 65 66 | 10 | 29 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) LITHUANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT William Savage ADDRESS 1245 James St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | CEREBRAL HEMORRHAGE | 3 DAYS |
| DUE TO | ARTERIOSCLEROSIS | |
| (B) | CARDIO-VASCULAR DISEASE | 9 YEARS? |
| DUE TO | ARTERIOSCLEROSIS | |
| (C) | PRIMARY ATYPICAL PNEUMONIA | 2 WEEKS |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| NONE | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 14 JUNE, 19 49 *to* 13 NOV, 19 49 *that I last saw the deceased alive on* 12 NOV, 19 49, *and that death occurred at* 5:10 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward J. Meier M. D. | 682 WASHINGTON BLVD | 14 NOV 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-16-49 | Holy Redeemer | Belair Rd Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M. D. | Elmer W. Fochtman | 703 Lucketts |

VS 150

937

G79879

BIRTH NO

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79878

1. NAME OF DECEASED (Type or Print): Clara Louise Regester Loweree

2. DATE OF DEATH: 11/13/49

3. PLACE OF DEATH
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Chadford Apartments University Apts. & Roland Av.
C. Length of stay in Baltimore: 80 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): University Parkway & Roland Aves.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 11/13/69
9. AGE (In years last birthday) Months Days Hours Min. (If Under 1 Year / If Under 24 Hours): 80
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Wilson
14. MOTHER'S MAIDEN NAME: Clara Church
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edgar R. Loweree ADDRESS: Chadford Apts.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) Coronary Sclerosis — 3 yrs
DUE TO

(C) Arteriosclerosis — ? yrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT SUICIDE HOMICIDE (Specify): —
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Feb 1949 to Nov 13, 1949, that I last saw the deceased alive on Nov 13, 1949, and that death occurred at 6:20 p.m., from the causes and on the date stated above.

23A. SIGNATURE: Francis W Glucr M.D.
23B. ADDRESS: 3406 St Paul St
23C. DATE SIGNED: 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/16/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Lorraine
24D. LOCATION (City, town or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. W. Wagaman and Son ADDRESS: 805 N. Calvert St.

VS 150

94a

G79880
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 974.0 G79880
Registered No.

1. NAME OF DECEASED (Type or Print): LOUIS W. NOVAK N-991
2. DATE OF DEATH: November 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 417 S. Bond Street 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | July 27, 1912 | 37 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | Bethlehem Ship Yard | Baltimore, Maryland | USA |

13. FATHER'S NAME: James Novak
14. MOTHER'S MAIDEN NAME: Frances CYWINSKA

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | 216-10-4655 | Anna Novak | 417 S. Bond Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation
DUE TO hanging

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 417 S. Bond Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): November 14, 1949 ? A m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by necktie—tied to doornob

22. *I certify that I took charge of the remains described above, held an* Insp. & inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-14-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 17-1949 | Holy Rosary | Balto. Co. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. S. Fiallkowski
ADDRESS: 2007 Eastern Ave

VS 151

164a

G79881

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450.1 G79881

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Pumphrey, Miss. Carrie May

2. DATE OF DEATH Nov. 13, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 700 W. 40th St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | May 10, 1871 | 78 | 6 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME Thomas Pumphrey

14. MOTHER'S MAIDEN NAME Sarah Frances Cooper

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mary E. Wharton R.N. | Home for Incurables |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Gangrene right leg | 3 weeks |
| DUE TO (B) | Generalized Arteriosclerosis | 5 years + |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arthritic changes, multiple joints | 5 years + |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 14, 1945 *to* Nov. 13, 1949 *that I last saw the deceased alive on* * , 19 , *and that death occurred at* 12:10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Connor Wolf M. D. | 11 E. Chase St. Baltimore 2 | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

* Dr. W. Grafton Hemperley saw her alive and attended her during my absence on Saturday P.M. November 12th 1949 5/13

G79882

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79882

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MERRY E. BANDEL

2. DATE OF DEATH: Nov. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3006 Ken Oak Rd.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3006 Ken Oak Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | married | May 15, 1869 | 80 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Louisiana | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. William M. Bandel | 3006 Ken Oak Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | 1) Coronary Decompensation | 48 hrs |
| DUE TO | 2) Arteriosclerosis | unknown |
| (B) DUE TO | Shock from Intestinal Obstruction 3) relieved after 12 hrs | |
| (C) | Age — 80 yrs | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 12, 1949, *to* Nov 13, 1949, *that I last saw the deceased alive on* 11-13-, 1949, *and that death occurred at* 1.45 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. B. Esser M. D. | 7201 York Rd | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/14/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

94a

Robius

679883

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 1

679883

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) MATTIE Robius

2. DATE OF DEATH Nov. 14 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 30N. Mount ST.

c. Length of stay in Baltimore 15 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 30N. Mount St. 19-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widow | 1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Va. | |

13. FATHER'S NAME Thomas Turner

14. MOTHER'S MAIDEN NAME Polly Artis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Elizabeth Barnes, 30N. Mount St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Several Days

DUE TO

(B) Cardio-Renal Disease — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1948 *to* Nov. 14, 1949, *that I last saw the deceased alive on* Nov. 14, 1949, *and that death occurred at* 4:10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard H. Hunt, M. D. | 1631 W. Franklin St. | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17-49 | Norfolk. Va | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | James A. Taylor | 638 N. Gilmor St. |

VS 150

1310

G79882

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G79882

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Desmond O'Connor

2. DATE OF DEATH Nov. 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Twilight Nurse Home

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twilight Nursing Home

C. Length of stay in Baltimore Unknown Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
122 Market Place
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1913 Eutaw Place 14-01
D. STREET ADDRESS (If rural, give location) Unknown

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Unknown | Oct. 19 1882 | 67 | | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unknown | Unknown | Unknown | Yes |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | Unknown | Twilight Nursing Home 1913 Eutaw Place |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) cerebral hemorrhage | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 1, 1949, *to* Nov. 11, 1949, *that I last saw the deceased alive on* Nov. 10, 1949, *and that death occurred at* 1 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. H. Cutterman M. D. | 2324 Reisterstown Rd | 11/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 16, 1949 | New Cathedral Cemetery | Edmondson Avenue |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 15 1949 | Emma Lee Williams, Mrs | David R. Martin 1902 Eutaw Pl. |

David R Martin

VS 150

832a

G79885

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79885
Registered No.

1. NAME OF DECEASED (Type or Print): Stephen Marshall Majchrzak
2. DATE OF DEATH: 11/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 203 Dallas Crt
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 203 Dallas Crt

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Separated | Dec. 20-1898 | 50 | 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Wholesale Fish Salesman | | Baltimore Md | |

13. FATHER'S NAME: George Majchrzak
14. MOTHER'S MAIDEN NAME: Mary Rudzynske

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 217-01-5361 | John Majchrzak | 527 N. Glover st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: Feb 15, 1949
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Feb 15 1949 to Nov 15, 1949 that I last saw the deceased alive on Nov 14 1949, and that death occurred at 9 A. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nelson L. Solomon M. D. | 129 S. Broadway | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 17-1949 | St. Stanislaus | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | George A. Weber | 705 S. Ann st |

VS 150

12B

G79886

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79886

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND W BEAN

2. DATE OF DEATH 14 NOV. 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY HOSPITAL
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) OWINGS MILLS
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | Nov 17, 1895 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RAILROAD | RAILROAD | Howard Co Md | U S |

13. FATHER'S NAME George T. Bean

14. MOTHER'S MAIDEN NAME Montmorency

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Lula E Bean | Owings Mills |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 MO.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CEREBRAL ARTERIOSCLEROSIS

DUE TO

(C) GENERALIZED ARTERIOSCLEROSIS

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 14 NOV, 1949 *to* 14 NOV, 1949 *that I last saw the deceased alive on* 14 NOV, 1949, *and that death occurred at* 11:20 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert C Nagam M. D. | UNIVERSITY HOSPITAL | 15 NOV 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 18-49 | Druid Ridge | Balto Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | J T Elsner Sons | Reisterstown Md |

VS-15b

83 B

Huttenhauer X

G79887 — BALTIMORE CITY HEALTH DEPARTMENT — E 900.0 — G79887

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillian Huttenhauer Reed — 2. DATE OF DEATH: 11/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Md. Gen'l Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Glyndon
D. STREET ADDRESS (If rural, give location): 300 Central

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Nov 20 1862 | 86 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Penna | U.S. |

13. FATHER'S NAME: Alexander F Reed

14. MOTHER'S MAIDEN NAME: Phoebe M Bratt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: Virginia F Huttenhauer

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary infarct

DUE TO

(B) Fractured neck of left femur

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Uremia

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
for: Dr. Wm. G. Helfrich
Geo Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident | home | 300 Central Ave., Glyndon, Md. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 31, 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | slipped and fell down steps at home |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 11/15, 1949, *that I last saw the deceased alive on* 11/14, 1949, *and that death occurred at* 3:00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irvine W Inglis Jr M. D. | Md. Gen'l Hosp | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17-49 | All Saints | Reisterstown Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | J. T. Ellen Sons Reisterstown |

VS 150

186a

G79888

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79888

BIRTH NO.

1 NAME OF DECEASED (Type or Print) John Lewis Matthews

2 DATE OF DEATH Nov. 12, 1949

3 PLACE OF DEATH
A Baltimore City, Maryland 41 E. Montgomery St

B FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4 USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE 41 E. Montgomery St Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore
D STREET ADDRESS (If rural give location) 41 E. Montgomery St.

c. Length of stay in Baltimore 40 yrs. (Yrs. Mos. Days)

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| male ~~xxxxx~~ | white | married | Nov. 8, 1860 | 89 | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired waterman | boat | Accomac Co., Va. | USA |

13. FATHER'S NAME: John L. Matthews

14 MOTHER'S MAIDEN NAME: Sarah Deer

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT ADDRESS |
|---|---|---|
| no | none | Lucy Eades, 41 E. Montgomery St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute Cardiac Failure | 1 da |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | DUE TO (B) Arterio Sclerotic Cardio Vascular Renal Disease | 5 yrs |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT SUICIDE HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/31/49 *to* 11/12 19 49 *that I last saw the deceased alive on* 11/12 19 49 *and that death occurred at* 4.05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Joseph G. Faulkner M.D. | 629 Washington Blvd | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Nov. 16 1949 | Western | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 15 1949 | Huntington Williams M.D. | Howard H. Hubbard, 2503 Edmondson Av |

VS 150

131a

CERTIFICATE CORRECTED 11-28-49

G79889

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79888

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward A Duffy

2. DATE OF DEATH: Nov 13 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 812 N. Calvert St

c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY Balto City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-01

D. STREET ADDRESS (If rural, give location): 812 N Calvert st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | July 2 1876 | 73 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | | W Va | U S A |

13. FATHER'S NAME: John Duffy

14. MOTHER'S MAIDEN NAME: Julia Rooney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Irene Duffy ADDRESS 812 N Calvert

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

DUE TO

(B) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Arteriosclerosis, Senes — ?

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Rt Hemiplegia — 3 yrs ago

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Nov, 1949, to 13 Nov, 1949 that I last saw the deceased alive on 13 Nov, 1949, and that death occurred at 11:45A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Bryson M. D. | 4617 Old Frederick Rd. | 15 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 11-16-49 | Lorraine Park | Woodlawn Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: George A. Farley ADDRESS: Fulton and Fayette Sts

VS 150

94a

G79890

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4201 Registered No. G79890

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LILLIAN REDMAN CORKRIN

2. DATE OF DEATH: Nov. 14, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3317 Devonshire Drive
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1101 Eutaw Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| female | white | married | Mar. 9, 1871 | 78 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | home | Balto., Md. | |

13. FATHER'S NAME: Wm. J. Wheeler

14. MOTHER'S MAIDEN NAME: Amanda Wrightson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Margaret Neubauer | 3126 Winsor Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 day |
| DUE TO (B) | Generalized Arteriosclerosis | 10 years |
| DUE TO | Diabetes Mellitus | 5 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1948, *to* Nov 14, 1949 *that I last saw the deceased alive on* Nov 13, 1949, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nelson F. Redman M. D. | 6 E Biddle St | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Tuttington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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G79891 G79891

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Ford
2. DATE OF DEATH: 10/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Womens Hospital
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 841 Decatur St. 13-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Girl | White | | 10/31/49 | | | 6 / 25 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Baltimore, Md. | USA |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Flora Sanders

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | none | mother | as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) asphyxia
DUE TO
(B) premature birth
DUE TO
(C) accident - contusions

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
due to ambulance hitting a car

INTERVAL BETWEEN ONSET AND DEATH: 5 hr 25 min

CERTIFICATION APPROVED BY
B B Fisher M.D.
MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | street | North + Mount Royal St. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10/31/49 1:30 P.M. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Fire Dept. ambulance hit a car on way to hospital |

22. *I hereby certify that I attended the deceased from* 1:40 PM 10/31, 1949 *to* 6:40 PM 10/31, 1949 *that I last saw the deceased alive on* 10/31, 1949, *and that death occurred at* 6:40 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William D. Spencer Jr. M. D. | Hosp. for Women of Md. | 10/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 1 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 5 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

OVER

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G79892

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79892 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Irene Burgess

2. DATE OF DEATH Nov 12 1949

3. PLACE OF DEATH: A Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1630 Abbott St

c. Length of stay in Baltimore 11 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1630 Abbott St 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If under 24 Hours Hrs. | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col. | Married | April 10 1900 | 49 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Littleton N. C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Young | Mary Giles |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | - | Edward Williams | 1630 Abbott St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) hypertensive cardiorenal disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/10, 1949 *to* 11/12, 1949 *that I last saw the deceased alive on* 11/11, 1949 *and that death occurred at* 9-18 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] | [illegible] EAST MADISON ST BALTIMORE, MD. | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov 15 1949 | | Littleton N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 15 1949 | Huntington Williams, M.D. | Mrs Robert Elliott & Daughter | 1310 1129 N. Caroline St |

VS 150

G79893 G79893

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 416

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles E. Francis Sr.

2. DATE OF DEATH: 11/14/1949 11:30 a.m.

3. PLACE OF DEATH: A. Baltimore City, Maryland Northern Pkwy + Charles St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Mem Hosp (B. 04)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 309 W. Joppa Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 5/16/1883 | 66 | 6 | 8 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | Jeffery-Dyer Co | Balto. Co. Md. | |

13. FATHER'S NAME: Charles A. Francis

14. MOTHER'S MAIDEN NAME: Mary Ann Corbin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Chas. E. Francis Jr. | 435 Alabama Rd Towson Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Dilatation of Heart — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

(B) Congestive Failure — 7 weeks

DUE TO

(C) Rheumatic Heart Disease — 45 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept, 1949, *to* Nov, 1949, *that I last saw the deceased alive on* Nov 12, 1949, *and that death occurred at* 10:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thos. F. Sadlack, M.D. | Towson 4, Md | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/17/49 | Prospect Hill | Towson Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 1217 St Paul St |

VS 150

95B

G79894

MS--133176

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

151

G79894
Registered No.

1. NAME OF DECEASED (Type or Print): Hans Hartung

2. DATE OF DEATH: 11-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 24 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1520 Eastern Ave. 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9-23-1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender
10B. KIND OF BUSINESS OR INDUSTRY: Tea. Taylor

11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Gens Peter Hartung
14. MOTHER'S MAIDEN NAME: Anna Christensen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 238-16-2578

17. INFORMANT: Records--4940 Eastern Ave. ADDRESS: Baltimore City Hospitals

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Generalized carcinomatosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Post op sub-total gastrectomy | |
| DUE TO | | |
| | (C) Carcinoma of the stomach | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-9-49 | Carcinoma Stomach | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-3- , 1949, *to* 11-15- , 1949 *that I last saw the deceased alive on* 11-15- , 1949, *and that death occurred at* 8:20 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. L. Bagen M.D. | B.C.H.--4940 Eastern Ave. | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-18-49 | Baltimore Cem. | E. North Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Wm. Cox & Jones | 121 St Paul St |

VS 150

46B

G79895

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 446

G79895

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eugene N. Thorn

2. DATE OF DEATH Nov 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lorley, Md.
D. STREET ADDRESS (If rural, give location) Rural

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 23rd 1872 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Agent ~~Electrical Engineer~~ | B & O | Balto. Md. | |

13. FATHER'S NAME Chas. A. Thorn

14. MOTHER'S MAIDEN NAME Mary A. ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Roger Thorn - Lorley | Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO
(B) Hypertension 210-250 / 110-130 —
DUE TO
(C) arteriosclerosis and Renal Insufficiency —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 18 1914 *to* Nov 14, 1949 *that I last saw the deceased alive on* Nov. 14, 1949 *and that death occurred at* 6:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A Luetscher, M. D. | 12 Wrager St | Nov 14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/17/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Wm Cook Inc | 127 St. Paul St |

VS 150

97

C79896

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. C79896

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES E. ALSBROOKS
2. DATE OF DEATH: 11-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1510 E. MONUMENT ST.
c. Length of stay in Baltimore: 25 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 7-0
D. STREET ADDRESS (If rural, give location): 1510 E. MONUMENT ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | C. | MARRIED | 8-12-1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MACHINE OPERATOR | MUTUAL CHEMICAL | S. C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Rafford ALSBROOKS | CAROLINE Mc INTYRE |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | MARTHA ALSBROOKS 1510 E. MONUMENT |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemmorrhage & Hemiplegia | Ab. 3 days |
| DUE TO (B) | Arteria Sclerosis | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Aortic Insufficiency, Chronic Pancreatitis, Nephritis & Malaria | 25yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 24, 1949 *to* Nov. 13, 1949 *that I last saw the deceased alive on* Nov 13, 1949, *and that death occurred at* 2:15 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph J. Young M. D. | 1429 E Monument St | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-16-49 | ARBUTUS MEM. PK | ARBUTUS, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Joseph D. Locks Jr. 1304 N. Central Ave |

VS 150

131a

G79897

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79897

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JOHN C. HART

2. DATE OF DEATH: 11/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 255 S. ELLWOOD AVE.
c. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 255 S. ELLWOOD AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | WIDOWED | 5/20/1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| BOILERMAKER | | GERMANY | U.S.A. |

13. FATHER'S NAME: ADAM HART

14. MOTHER'S MAIDEN NAME: UNKNOWN

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | ANNA HALTHAUS | 7707 QUEEN ANN DR. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.)

(A) Congestive Heart Failure (Myocarditis)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senescent Arteriosclerosis

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1949, *to* 11-13, 1949, *that I last saw the deceased alive on* 11-13, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Todd M. D. | 736 E. Fayette St | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11/16/49 | HOLY REDEEMER | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | WILLY & ZEILER INC. | BALTO. |

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MS--55899

G79898

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.0

G79898 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Latchford

2. DATE OF DEATH: 10-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Yrs. life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Inf.)
D. STREET ADDRESS (If rural, give location): Baltimore City Hospitals Infirmary

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | March 25, 1862? | 87 ? | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank
14. MOTHER'S MAIDEN NAME: Martha McDonough ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: Baltimore City Hospitals Records--4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-24- , 1940 *to* 10-29- , 1949, *that I last saw the deceased alive on* 10-29- , 1949, *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City, town, or county) (State):

UNIVERSITY MEDICAL SCHOOL NOV 7 1949

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR:
ADDRESS:

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VS 132822 G79899

BIRTH NO. 49-13175

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

571.0 G79899 Registered No.

1. NAME OF DECEASED (Type or Print) Carl Westley Switzer

2. DATE OF DEATH 11-2-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 119 W. Barre St. 22-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | June 7, 1949 | | 4 | 25 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Carl Switzer

14. MOTHER'S MAIDEN NAME Mollie Bryant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Records--Baltimore City Hospitals ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Diarrhea, due to Malnutrition
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-22- , 19 49 *to* 11-2- , 19 49 *that I last saw the deceased alive on* 11-2- 19 49 *, and that death occurred at* 1:35 P m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 4940 Eastern Ave.

23C. DATE SIGNED 11-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL NOV 10 1949

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 16 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR

ADDRESS

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G79900 2020 N Charles G79900

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Sidney V. Ross

2. DATE OF DEATH Nov 14-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3652 Beech AVE

c. Length of stay in Baltimore 70 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3652 Beech Ave 13-07

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH July 26-1864 | 9. AGE (In years last birthday) 85 | If under 1 Year: Months 3 Days 18 | If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Ford

14. MOTHER'S MAIDEN NAME Elizabeth Denison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO —

17. INFORMANT Stanley Ross ADDRESS 3651 Chestnut Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 48 hours |
| DUE TO (B) | Arteriosclerosis | indef. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cardiac Insufficiency | Indefinite |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February, 1948 to 14 Nov, 1949 *that I last saw the deceased alive on* 14 Nov, 1949, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE Olive B Watts M.D. | 23B. ADDRESS 2020 N Charles St | 23C. DATE SIGNED 15 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Nov 17-49 | 24C. NAME OF CEMETERY OR CREMATORY St Marys | 24D. LOCATION (City, town, or county) Hampden Balto Md (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 16 1949 | REGISTRAR'S SIGNATURE Huntington Williams, MD | 25. FUNERAL DIRECTOR Frank H Seitz ADDRESS 814 W 36th St

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G79901

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 34

G79901 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JULIA DOLBOE CHASE

2 DATE OF DEATH Nov. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 Upland Rd.

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4 Upland Road 27-14

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | Oct. 7, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md. | USA |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| Reuben Dolbow | Annie E. Taylor |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | 4 Upland Road - 10 Mrs. W. Guy Delahay (Daughter) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure
DUE TO
(B) Cerebral and general
DUE TO
(C) arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | | YES NO X |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* July 15, 1947, *to* Nov 13, 1947, *that I last saw the deceased alive on* Nov. 13, 1947. *and that death occurred at* 12-50 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. W. Smith M. D. | 3429 Chestnut Ave. | Nov 14, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/16/49 | Parkwood Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 16 1949 | Hunting for Williams, M.D. | HENRY SANDER & SONS, INC. |

VS 150

97

G79902

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79902 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY C. CLARK
2. DATE OF DEATH: 11-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PARKMONT NURSING HOME 4212 PARKMONT AVE
C. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 13-07
D. STREET ADDRESS (If rural, give location): 3706 HICKORY AVE

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): S
8. DATE OF BIRTH: JULY 2 1898
9. AGE (In years last birthday): 51 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BARTENDER
10B. KIND OF BUSINESS OR INDUSTRY: C. W. GRIFFITH
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: HARRY C. CLARK
14. MOTHER'S MAIDEN NAME: LILLY M. SPILLMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: FRANK P. CLARK - 406 N. CURLEY ST.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral & Pulmonary Metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO
(B) Nephroto Carcinoma (Rt) — 1 yr.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT SUICIDE. HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Aug 1, 1949 *to* Nov 14, 1949, *that I last saw the deceased alive on* Nov 13, 1949, *and that death occurred at* 9:55 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert B. Tunney M. D.
23B. ADDRESS: 920 St Paul St
23C. DATE SIGNED: 11-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 16/49
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Hampden
24D. LOCATION (City, town, or county) (State): Roland Ave. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Austin E. Donovan
ADDRESS: 3818 Roland Ave

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G79903

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79903

BIRTH NO. 49-24671

1. NAME OF DECEASED (Type or Print): Baby Boy French

2. DATE OF DEATH: 11/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 813 William Street 22-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11/9/49
9. AGE (In years last birthday) — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.: 1

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Bernard Freach, Jr.
14 MOTHER'S MAIDEN NAME: Mary E Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mary Franch- 813 William St. Balto. Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B) Rupture at 24-26 wks
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/9, 1949, *to* 11/9, 1949, *that I last saw the deceased alive on* 11/9, 1949, *and that death occurred at* 6:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 1213 Light Street
23C. DATE SIGNED 11/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): NOV 14 1949

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR — ADDRESS

VS 150

159

G79904

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

716

G79904 Registered No.

BIRTH NO. 49-21129

1. NAME OF DECEASED (Type or Print): Baby Boy Gasiorowski

2. DATE OF DEATH: Oct. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 505 S. Bond St. # 31 2-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | S | Oct. 1, 1949 | | | 3 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thadeous Gasiorowski

14. MOTHER'S MAIDEN NAME: Effie Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother ADDRESS: 505 S. Bond St. # 31

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1949, *to* Oct. 4, 1949, *that I last saw the deceased alive on* Oct 4, 1949 *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Sidney Green M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: Nov 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): NOV 14 1949

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: ADDRESS:

VS 150

159

G79905

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

491

G79905

BIRTH NO. 48-02864 Registered No.

1. NAME OF DECEASED (Type or Print): DIDRA MURRAY

2. DATE OF DEATH: November 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 718 N. Fulton Avenue 16-04

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: Feb. 4/48
9. AGE (In years last birthday): 1 — If under 1 Year: Months 9; Days; If under 24 hours: Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Murray
14. MOTHER'S MAIDEN NAME: Sarah Balis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Frank Balis — ADDRESS: 714 N. Fulton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO
(B) Rickets

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Royster M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-15-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-18-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Haleteed
ADDRESS: 918 Druid Hill ave. 107

VS 151

G79906

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH E981

G79906

Registered No.

1. NAME OF DECEASED (Type or Print): Alfred Henry Davis N-853.4

2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): N. 114 Poppleton St. 18-01

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 3/17/1931

9. AGE (In years last birthday): 18
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Davis

14. MOTHER'S MAIDEN NAME: Alice Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: James E. Davis-601 N.Paca St
ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gun Shot wound of brain

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Found lying in front

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): of 11 N. Schroder St. near Fairmont

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 12, 1949 2 A.m.

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23a. SIGNATURE: W. J. McCafferty M.D.

23b. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23c. DATE SIGNED: Nov. 12, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/17/49

24c. NAME OF CEMETERY OR CREMATORY: Mt Auburn

24d. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas H Corpe Sr

ADDRESS: 512 Cantrell Ave

VS 151

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G79907 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79907 Registered No.

1. NAME OF DECEASED (Type or Print): Josephine FUNN
2. DATE OF DEATH: 11.13.49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1317 Madison Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bar-Wil-Ba Convalescent Home
C. Length of stay in Baltimore: 40 Yrs. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1317 Madison Ave 11-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | colored | SEPARATED | 11/24/1885 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | Private Home | Maryland | U.S.A. |

13. FATHER'S NAME: James Jackson
14. MOTHER'S MAIDEN NAME: Harriet Young

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | no | none | George D. Johnsen | 1315 Edmondson Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Cerebral Hemorrhage | 11 days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Senile Dementia | 2 yrs. |
| DUE TO | | |
| (C) | arteriosclerotic cardiovascular Disease | 2 yrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10.2 *,* 19 47 *to* 11.13. *,* 19 49 *that I last saw the deceased alive on* 11.7. *,* 19 49 *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James M. Pair M. D. | 400 N. Carrollton ave | 11.14.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Mt Auburn | Balto md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Chas H Harper | 572 Carrollton Ave |

VS 150

93D

G79908

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79908 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROSE SILVERMAN

2. DATE OF DEATH: Nov. 16 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-0 v
D. STREET ADDRESS (If rural, give location): 1805 E Baltimore Maryland.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Min. |
|---|---|---|---|---|---|---|
| Female. | White. | widowed. | 1883 | 66 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): England.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rubin Freeman

14. MOTHER'S MAIDEN NAME: Rachel Radesky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Posterior Myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetis Mellitus.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 19 49 *to* 11-15, 19 49 *that I last saw the deceased alive on* 11-15, 19 49, *and that death occurred at* 1:18 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Huntington Mach. M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 11-15-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17, 1949 | Hebrew Washington Rd Cem | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS 1126 W North Ave

VS 150

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G79909 X ✓ G79908

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 43 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): IRMA GERTRUDE SHEELY

2. DATE OF DEATH: Nov 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson 4, Md.
D. STREET ADDRESS (If rural, give location): Aintree Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Aug 5, 1902 | 47 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto. Md. | America |

13. FATHER'S NAME: Frederick C. H. Wessel

14. MOTHER'S MAIDEN NAME: Ida Gertrude Breeden

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | | Mr. Harry M. Sheely | Keyser Bldg. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Heart Disease of Unknown Etiology | 50 days |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| Oct 26, 1949 | 2000 cc of clear straw colored fluid in peritoneal cavity | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 24, 1949, *to* Nov 14, 1949, *that I last saw the deceased alive on* Nov 14, 1949, *and that death occurred at* 11:45 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Frank Snyder, III M. D. | Union Memorial Hosp. | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/17/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Tunstall Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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BALTIMORE CITY HEALTH DEPARTMENT 443 G79910

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY ISABELLE O'CONNELL

2. DATE OF DEATH Nov. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1 W. Franklin St. 4-01

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 West Franklin St.

e. Length of stay in Baltimore Yrs. Life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Aug. 21, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| unknown | Unknown | Ireland | U.S.A. |

13. FATHER'S NAME Thomas O'Connell

14. MOTHER'S MAIDEN NAME Sarah Conway

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | Mrs Robert Cunbanter | 4108 Wabash |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Hypertensive Cardio-Vascular disease with cardiac hypertrophy & Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 5 mo.

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 6/1 1949 to 11/14, 1949, that I last saw the deceased alive on 11/14, 1949 and that death occurred at 6 P. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jos. Tumulty M. D. | Medical Arts Bldg | 11/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 17, 1949 | New Cathedral Cem. | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | John A. Moran | 3000 E. Balto St, Balto 24, Md. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 G79911 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Grier Simington Robertson

2. DATE OF DEATH: November 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4307 Falls Road

c. Length of stay in Baltimore: 24 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4307 Falls Road 27-14

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 25, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Confectionery | Retired 5 yrs. | Maryland | U S A |

13. FATHER'S NAME: Jesse Robertson

14. MOTHER'S MAIDEN NAME: Eliza Jane Buckingham

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 216-24-1100 | Mrs. Junie G. Robertson | 4307 Falls Road |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
DUE TO
(B) Hypertensive CVD
DUE TO
(C) Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 1926 *to* Nov 15, 1949 *that I last saw the deceased alive on* Nov 15, 1949 *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Laurence H. Lumsden M. D. | 3716 Falls Rd | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 18, 1949 | Stone Chapel | near Westminster, Carroll Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | | Burgee Funeral Home | 3631 Falls Road |

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**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 33

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry EUGENE Mixter

2. DATE OF DEATH Nov. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4111 Falls Rd

c. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md- B. COUNTY Baltimore.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 4111 Falls Rd. 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | AUG 25, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Street Car Operator | Balto. Transit Co. | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Mixter | Mary Wise |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 213-10-0935 | WIFE MRS. EDITH N. MIXTER | 4111 Falls Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Accident — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) 11 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NO | None | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 28, 1949, *to* Nov. 13, 1949, *that I last saw the deceased alive on* Nov. 13, 1949, *and that death occurred at* 7A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Emmett Queen M. D. | 101 W. Read St. Balto. | Nov 14, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Nov. 17-1949 | Mount Olivet | Frederick, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Courtney O | Burgee Funeral Home | 3631 Falls Road |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 4720

1. NAME OF DECEASED (Type or Print) John A. Munzert

2. DATE OF DEATH Nov. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Manchester
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct 14, 1880 | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ra. Rail Road ENGINEER
10B. KIND OF BUSINESS OR INDUSTRY RETIRED 10 YRS.
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John A. Munzert
14. MOTHER'S MAIDEN NAME Annie Sudel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT MRS. MAE R. MUNZERT ADDRESS MANCHESTER MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebro Vascular Accident | minutes |
| DUE TO (B) | Arterio Sclerotic Heart disease | years |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchogenic Carcinoma | months |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 9, 1949 *to* Nov. 14, 1949, *that I last saw the deceased alive on* Nov 14, 1949, *and that death occurred at* 10:35 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Frank Supplee, III M. D. | Union Memorial Hosp. | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 17-1949 | St. Mary's (Hampden) | Baltimore Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 19 | Huntington Williams M.D. | Burgee Funeral Home | 2631 Folk Road |

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G79914 — BALTIMORE CITY HEALTH DEPARTMENT — G79914

# CERTIFICATE OF DEATH

Registered No. E812.4

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (Kathryn) KATHERINE E. NORWOOD N-803.

2. DATE OF DEATH: November 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 3001 Larvine Road 3001 Lawina Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | May 24,1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Beautician | Dunns Beauty Shop | Md. | |

13. FATHER'S NAME: J. H. Bixler

14. MOTHER'S MAIDEN NAME: Martha E. Cox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212 16 6910

17. INFORMANT (Husband) ADDRESS: Harvey Norwood, 3001 Lawina Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fractured skull | |
| | XXXXX Intracranial hemorrhage | |
| | Contusion of brain | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North Avenue & Carey Street 15/1

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): November 13, 1949 ? P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 11-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 17, 1949

24C. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE

24D. LOCATION (City, town, or county) (State): PIKESVILLE, MD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949

REGISTRAR'S SIGNATURE: Huntington Hollins, M.D.

25. FUNERAL DIRECTOR ADDRESS: Harry F. Nuttle, 4101 Edmondson Ave

170C

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# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79915

331 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry A. Keim

2. DATE OF DEATH: Nov. 13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1726 Wilmington Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1726 Wilmington Ave.

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| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct. 28/83 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Receiving Clerk | A. & P. Store | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Keim | Amelia-------- |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 216 09 1903 | Mrs. Alice A. Keim, 1726 Wilmington Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — (Interval between onset and death) 18 hrs.

DUE TO

(B) Essential Hypertension — over 2 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan. 19, 1948 *to* November 13, 1949, *that I last saw the deceased alive on* Nov. 13, 1949, *and that death occurred at* 10 3/5 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Arthur Rossberg M.D. M. D. | 2411 Washington Blvd-30 | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 16/49 | Loudon Park | 3801 Frederick Rd. Balto. md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Registrar for Maryland, M.D. | Harry A. Nitsche | 4101 Edmondson Ave. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET HARBAUGH
2. DATE OF DEATH: 11/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTIMORE HOSP.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE MD. 23
D. STREET ADDRESS (If rural, give location): 1217 PATAPSCO ST 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEM | WHITE | SINGLE | SEP 10-1915 | 34 | 2 | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | | BALTIMORE 1 | MD |

13. FATHER'S NAME: SAMUEL HARBAUGH
14. MOTHER'S MAIDEN NAME: MARY C WAGNER ~~1217 PATAPSCO ST~~

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| | | |

17. INFORMANT: MARY C WAGNER ADDRESS: 1217 PATAPSCO

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/15 *1949 to* 11/16, *1949 that I last saw the deceased alive on* 11/16, *1949 and that death occurred at* 3 P.M. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D Yeniman M. D. | 213 Light Street | 11/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV 19-49 | HOLY CROSS CEM | A A CO |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Registrar for Baltimore, Md. | Bernard C Hasle | 1216 W Fay St |

VS 150

107

G79917

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Reg. No. G79917 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK PAULOVICH

2. DATE OF DEATH November 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 407 Patapsco Avenue
C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 407 Patapsco Avenue 25-04

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED
8. DATE OF BIRTH OCT-28-1883
9. AGE (In years last birthday) 66
If Under 1 Year: Months 0 Days 18
If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Steam Eng.
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) AUSTRIA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOHN. PAULOVICH.
14. MOTHER'S MAIDEN NAME TINA. KANDELARI.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 216-12-9950
17. INFORMANT MARY POULOVICH ADDRESS 407 PATAPSCO AVE

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary occlusion | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Wm. N. Kammerer Jr. M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED Nov. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE NOV-18-49
24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM
24D. LOCATION (City, town, or county) (State) ANNE ARUNDEL CO MD

DATE RECEIVED BY LOCAL REGISTRAR NOV 15 1949
REGISTRAR'S SIGNATURE Transcription Witness, MD
25. FUNERAL DIRECTOR Bernard G Hurle ADDRESS 121 E West St

94a

VS 151

G79918

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1 G79918

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nicholas Andrew Ellinghaus

2. DATE OF DEATH 11/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4500 Kathland Avenue
C. Length of stay in Baltimore 64 Yrs. 28 Mos. 07 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4500 Kathland Avenue

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Sept. 6, 1885
9. AGE (In years last birthday) 64 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Comm. Engineer
10B. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co.
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick William Ellinghaus
14. MOTHER'S MAIDEN NAME Cecilia Saur

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs. N. A. Ellinghaus ADDRESS 4500 Kathland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis | 10 hours |
| DUE TO | | |
| (B) | Coronary Sclerosis | 6 years + |
| DUE TO | | |
| (C) | Arteriosclerotic Cardio-Vasc. Disease | 6 years + |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* February 1944, *to* November 15, 1949, *that I last saw the deceased alive on* November 16 1949, *and that death occurred at* 7.45 a m., *from the causes and on the date stated above.*

23A. SIGNATURE Thomas Conrad Wolf M. D.
23B. ADDRESS 11 E. Chase St. Baltimore 2 MD
23C. DATE SIGNED 11/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11/18/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. W. Meakins Son
ADDRESS 805 N. Calvert St.

93D

G79919

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

G79919 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mollie Harvey

2. DATE OF DEATH: 1949 November 15

3. PLACE OF DEATH: A. Baltimore City, Maryland 2100 Rupp St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. 2100 Rupp St.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2100 Rupp St. 15-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year Months Days | If under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| F | C | W | 2-6-73 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Louisa Co. Va. | U. S. A. |

13. FATHER'S NAME: Harvey Wilson

14. MOTHER'S MAIDEN NAME: Lucy Winston

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | | Mabel Williams 2100 Rupp St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral thrombosis | |
| DUE TO | | |
| (B) | Generalized arteria sclerosis | |
| DUE TO | | |
| (C) | Hypertension | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 4 *19* 49 *to* Nov. 15, *19* 49 *that I last saw the deceased alive on* Nov. 14, *19* 49 *and that death occurred at* 1 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas Anderson M. D. | 612 Edmondson Ave | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49 | Mt Auburn | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Geo. C. Nelson 1303 Presstman St. |

VS 150

838

G79920

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79920

1. NAME OF DECEASED (Type or Print): MARY A. O'CONNOR

2. DATE OF DEATH: NOV. 14. 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2018 JEFFERSON

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
2018 E JEFFERSON
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. Md.
D. STREET ADDRESS (If rural, give location): 2018 E JEFFERSON 7-05

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F. | W. | WIDOW | JAN. 3, 1875 | 74 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTO. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Geo KOHLER.
14. MOTHER'S MAIDEN NAME: MARTHA ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Marg. Baker 2018 E Jefferson St.
ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Edema 3 hrs.
DUE TO
(B) Myocardial Degeneration ?
DUE TO
(C) Pneumonia 4 wks. ago

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
Arteriosclerosis - generalized

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 1940 to Nov. 14, 1949, *that I last saw the deceased alive on* Nov. 13, 1949, *and that death occurred at* 12.40 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lawrence Kleiner M.D. | 2623 E. Monument St | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV. 17. 49 | NEW CATH. CEM | BALTO Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | PAUL A. HECMANN | 6067 Harford Rd |

93D

G79921

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 60.0.

G79921 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN F. HUYER JOHN HUYER ?

2. DATE OF DEATH 11-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore UNK'N (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 12-02
D. STREET ADDRESS (If rural, give location) UNION MEMORIAL HOSPITAL

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | 3-12-1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PORTER | HOSPITAL | NETHERLANDS | USA |

13. FATHER'S NAME PETER HUYER

14. MOTHER'S MAIDEN NAME WILHELMINA BEMELMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN

16. SOCIAL SECURITY NO

17. INFORMANT PATIENT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Septicemia, severe | 24 HRS |
| DUE TO (B) | Pyelonephritis, Acute, bil. | UNKNOWN |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-19-49 | LEGG-PERTHES DISEASE. | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Charles H. Watt Jr. M. D. | Union Memorial Hospital | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 17/49 | Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 VS Rec'd | Lucy Washington Williams, M.D. | Chas. F. Evans & Son, Inc. | 118 W. Mt. Royal ave. 123a |

G79922 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 9 10.3 G79922

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print) THEODORE WINSTEAD N-803.?

2. DATE OF DEATH November 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5802 Osprey Lane 26-X-6

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 5/11/1907
9. AGE (In years last birthday): 42 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. C
12. CITIZEN OF WHAT COUNTRY? U. S

13. FATHER'S NAME: John Winstead
14. MOTHER'S MAIDEN NAME: Georgana Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Fannie Winstead ADDRESS 5802 Osprey Lane

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): old tunnell
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) old water tunnel on Liberty Road
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: November 14, 1949 2a.m.
21E. INJURY OCCURRED: WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? part of tunnel ceiling fell in

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Emil L Kaufman M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped
24B. DATE 11-17-49
24C. NAME OF CEMETERY OR CREMATORY Rotboro
24D. LOCATION (City, town, or county) (State) N C NC

DATE RECEIVED BY LOCAL REGISTRAR NOV 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Rayner Sanders ADDRESS 1412 E Preston St

182B

VS 151

G79923

BIRTH NO. G79923

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 43 Registered No.

1. NAME OF DECEASED (Type or Print): Charles Gore

2. DATE OF DEATH: Nov 9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1130 Low St

C. Length of stay in Baltimore: 10 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1130 Low St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | Married | | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | N. C | U. S |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Edith Harris 807 N Ausgusta St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8-5 19 46 *to* 11-9 19 49 *that I last saw the deceased alive on* 11-6 19 49 *and that death occurred at* 9 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] | BROWN'S EAST SIDE CEMETERY BALTIMORE MD | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-16-49 | Mt Calvary St Paul | a a Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Rayner Sinders 1412 E Preston St 93 |

VS 150

G79928 ✓ G79928

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert G Dunmore Sr. ?
2. DATE OF DEATH: NOV. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2639 FRANCIS ST
C. Length of stay in Baltimore: 50 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2639 Francis 13-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | COL | WIDOWED | Mar 3, 1880 | 69 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Richard Dunmore
14. MOTHER'S MAIDEN NAME: Mollie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert G. Dunmore Jr ADDRESS: 2639 Francis St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Myocardial Degeneration | 3 MOS |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Chronic Nephritis | 1 MOS |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 12, 1949 *to* NOV. 13, 1949 *that I last saw the deceased alive on* NOV. 13, 1949 *and that death occurred at* 4:10 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thomas Culbreth M. D.
23B. ADDRESS: 1543 Vernon Ave
23C. DATE SIGNED: 11/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/17/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Peters Memorial Park
24D. LOCATION (City, town, or county) (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joyner Sanders ADDRESS: 1412 E. Preston St

131B

G79925

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G79925 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida J. Hines — 134734
2. DATE OF DEATH: NOV 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: Baltimore (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 506 N. Eden St.

c. Length of stay in Baltimore: 5 yrs. (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | Colored | Widowed ? | Sept. 19. 1903 | 46 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | at Home | Va. | U.S.A. |

13. FATHER'S NAME: William Jones
14. MOTHER'S MAIDEN NAME: Augusta Doles

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial infarct | 12 hrs |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive cardiovascular disease | 15 yrs |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-13- 1949 *to* 11-14- 1949, *that I last saw the deceased alive on* 11-14- 1949, *and that death occurred at* 3:25 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David E. Rogers M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/16/49 | Mt Calvary Cem. | Brooklyn Md. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Registrar for Williams, M.D. | Elcoy O. Wilson | 1000 Brantley Ave |

VS 150

93D

BIRTH NO. G79928

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79928

1. NAME OF DECEASED (Type or Print): James J. Chaney
2. DATE OF DEATH: 11-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3619 Ellerslie Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminister
D. STREET ADDRESS (If rural, give location): 65 Pa. Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman - | Westminister Shoe Co | Baltimore, Md. | |

13. FATHER'S NAME: Everett Chaney
14. MOTHER'S MAIDEN NAME: Anna Joellner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 213-05-1632 | Mr. John Everett Chaney | 65 Pa. Avenue Westminster |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary thrombosis 4/3/49.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from May 31, 1949, to Nov. 13, 1949, that I last saw the deceased alive on Nov. 13 1949 and that death occurred at 7:30 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. C. Gotshall M. D. | 447 N. Kenwood Ave | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-16-49 | Holy Redeemer Cem. | - City - |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | WIEDEFELD AND SON | GREENMOUNT AVE & 31st |

VS 150
NOV 16 1949

Westminster, Md. 94a

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79927 Registered No.

BIRTH NO. G79927

1. NAME OF DECEASED (Type or Print): Henrietta McKnight. | 2. DATE OF DEATH: 11-12-1949.

3. PLACE OF DEATH: a. Baltimore City, Maryland Balto. 103 N. Schroeder
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 103 N. Schroeder St
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 16 04
d. STREET ADDRESS (If rural, give location): 103 N. Schroeder St..

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | Widow | 9-5-1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Newberry S.C. | U.S.A. |

13. FATHER'S NAME: John Williams.
14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | John C. Williams. | 1016 W. Wingston Salem, N.C. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 5, 1949 *to* June 12, 1949, *that I last saw the deceased alive on* June 12, 1949 *and that death occurred at* 7:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William H Watts M.D. | 515 Walbrook | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17, 1949 | Mt. Auburn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 3227 Schroeder St |

VS 150

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BIRTH NO. G79928

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G79928

1. NAME OF DECEASED (Type or Print): ROSIE KEENE
2. DATE OF DEATH: November 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1101 N. Stricker Street 1607

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | May 11, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Eastern Shore Md. | U.S.A. |

13. FATHER'S NAME: James Keene
14. MOTHER'S MAIDEN NAME: Kiziah Jeniper

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Stephen Keene | 1822 Carthage St. Balto. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive cardiovascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: C. J. Lubinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 11-14-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 17, 1949 | Taylor's Island | Eastern Shore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Katie R Williams
ADDRESS: 2224 N. Schroeder St

VS 151

1-93D

G79929 ✓ G79929

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 416

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Della W. Wilson

2. DATE OF DEATH: Nov. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Proj. Dent Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
1101 N Gilmore St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 16 Ward
D. STREET ADDRESS (If rural, give location): 1101 N Gilmore St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col | Widowed | 9/16/1900 | 49 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Va | |

13. FATHER'S NAME: James Harrison

14. MOTHER'S MAIDEN NAME: Florence Harris ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Samuel Wilson | 1101 N Gilmore St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Rheumatic carditis. | |
| DUE TO | ? | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Congestive heart failure | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/1, 1949, *to* 11/12, 1949, *that I last saw the deceased alive on* 11/15, 1949, *and that death occurred at* 2:30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis A. Lasma M.D. | Proj. Dent Hosp. | Nov. 15 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49 | Mt Auburn Cemt | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Isaac L Brown Son | 108 W Montgomery St |

Vs 150

587

G79930

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

31. G79930 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET M. LE DOYEN.

2. DATE OF DEATH: NOV. 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2921 HUNTINGDON AVE.
c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2921 HUNTINGDON AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | WIDOW | APRIL 4, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | — | MARYLAND. | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HUGH COLEMAN | ? CROSBY |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | HUGH B. LE DOYEN | 2921 HUNTINGDON AVE |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(B) Arteriosclerosis — Indefinite

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Hypertension, arteriosclerotic aortic stenosis (slight, mild) DIABETES MELLITUS — Indefinite 12 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* December 1947 *to* 15 Nov 1949, *that I last saw the deceased alive on* 15 Nov 1949 *and that death occurred at* 1 30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Peter B. Wirth M.D. | 3020 N. Charles St | 16 Nov 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 18/49 | Druid Ridge | Pikesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Interington Williams M.D. | Preston B. Donovan | 3818 Roland Ave. |

VS 150

61

G79931 BALTIMORE CITY HEALTH DEPARTMENT G79931

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) SETTIMO SERRA

2. DATE OF DEATH 11/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOSP.

c. Length of stay in Baltimore 44 Yrs. [redacted] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 5200 BEAUFORT 27-8

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 5, 1876
9. AGE (In years last birthday) 73 If Under 1 Year: Months, Days If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Cutter,
10B. KIND OF BUSINESS OR INDUSTRY Gen. Contracting
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrea Serra,
14. MOTHER'S MAIDEN NAME Maria Vacca.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO none
17. INFORMANT HOSPITAL RECORDS ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/13/49 19__, *to* 11/14/49 19__, *that I last saw the deceased alive on* 11/14/49, *and that death occurred at* 8:15 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Swirski M. D.
23B. ADDRESS St. Joseph's Hosp.
23C. DATE SIGNED 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11/18/49
24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery-Baltimore, Md.
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 16 1949
REGISTRAR'S SIGNATURE Limited for Williams, M.D.
25. FUNERAL DIRECTOR C. Vernon Lemmon, ADDRESS 4611 Park Heights Ave.

937

G79932 BALTIMORE CITY HEALTH DEPARTMENT G79932

BIRTH NO. G79932 **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Msgr Hugh Monaghan
2. DATE OF DEATH: 11/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp
c. Length of stay in Baltimore: 69 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural give location): Home He gives 4 W Ch aves) 4- Amhurst Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | 2/2/166 | 83 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pastor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Monaghan
14. MOTHER'S MAIDEN NAME: Anne Grimes (Anne Grimes)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Fr. Gamby ADDRESS: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerosis MD DUE TO | |
| | (C) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/3 19 49 *to* 11/14 19 49, *that I last saw the deceased alive on* 11/7/49 19___, *and that death occurred at* 1 5/8 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 11/14/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/17/49 | Cathedral | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: [signature] Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR ADDRESS: C. Vernon Lemmon, 4611 Park Heights Ave.

VS 150

93D

G79933 BALTIMORE CITY HEALTH DEPARTMENT G79933

# CERTIFICATE OF DEATH (djm)

BIRTH NO. Registered No. N-971.0

1. NAME OF DECEASED (Type or Print): Merle (Merrill) Fred (Dickson) (Denfoe) Densmore
2. DATE OF DEATH: Nov. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: (California) New Hampshire
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): (Los Angeles) Concord
D. STREET ADDRESS (If rural, give location): (1012 Laurence St) 24 S. State St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| W | M | | May 21, 1892 | 57 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Vermont | U.S.A. |

13. FATHER'S NAME: Fred F. Densmore
14. MOTHER'S MAIDEN NAME: not known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Harley Boutwell. F.D. | Concord, N.H. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Barbiturate poisoning | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Hotel | Mt. Royal Hotel |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. ? 1949 ? m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Ingestion of pills |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | | Nov. 12, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BOR Removal | 11/18/49 | Blossom Hill | Concord, N. H. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams M.D. | C. V. Lemmon | 4611 Pk Hgts. |

VS 151

163R

G79934 170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79934

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Langley

2. DATE OF DEATH: 11-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1215 E. Biddle Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widow | April 14, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Va | |

13. FATHER'S NAME: Thomas Slaughter

14. MOTHER'S MAIDEN NAME: Elizabeth Collins

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | RECORDS*BALTIMORE CITY HOSPITALS | 4940 Eastern Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriolar nephrosclerosis | |
| DUE TO | | |
| | (C) Hypertensive arteriosclerotic heart disease | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 11-3, 19 49 *to* 11-15, 19 49, *that I last saw the deceased alive on* 11-15, 19 49, *and that death occurred at* 2:35 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. S. Cozzen M.D. | 4940 Eastern Avenue | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-18-49 | Mt. Calvary | A. A. County, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Joseph S. Locke, Jr. | 1304 N. Central Ave |

VS 150

1310

G79935

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79935

1. NAME OF DECEASED (Type or Print): Emma Bushy

2. DATE OF DEATH: Nov. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 403 S. Vincent St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 403 S. Vincent St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | May 6 1910 | 39 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md | |

13. FATHER'S NAME: Charles Murphy

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 216-18-6920

17. INFORMANT: Mr. Elton Busby ADDRESS: 403 S. Vincent St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertension & Renal Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L. Kaye M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Nov. 15, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY, OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov-17-49 | Western Cemetery | Edmondson Ave. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. A. Strebinacka Jr ADDRESS: 1905 E. Eutaw St

VS 151

131a

G79936

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79936

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Nelson Corbin

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | Feb. 22, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John N. Corbin | Linda Routzhan |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis (one)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Uremia — DUE TO

(C) Nephrosclerosis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Benign prostatic hypertrophy

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Frank Supplee III M. D. | Union Memorial Hosp | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Nov 19-49 | Kriders | Carroll Co |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 18 1949 | Huntington-Williams, M.D. | H. Bankard. Inc Westminster Md |

VS 150

12B

G79937 6562

BALTIMORE CITY HEALTH DEPARTMENT 40.0 G79937

# CERTIFICATE OF DEATH 3

BIRTH NO. H-69574 Registered No.

1. NAME OF DECEASED (Type or Print): Maurice Marshall

2. DATE OF DEATH: 11-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-02
D. STREET ADDRESS (If rural, give location): 1305 Harlem Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | Jan. 30, 1947 | 2 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Willie Moses
14. MOTHER'S MAIDEN NAME: Jessie Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals ADDRESS: 4940 Eastern Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Post H. influenzal meningitis | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cerebral atrophy | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-2- , 1949 *to* 11-15 , 1949 *that I last saw the deceased alive on* 11-15 1949 *and that death occurred at* 8:40 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: J. S. Logan M.D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 11-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-18-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): B. B. Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead - 908 Druid Hill Ave
ADDRESS:

VS 150

33R

G79938

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79938

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County Balto City
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 N. Hilton Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Lee Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | single |

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | — | 14 | hr. min. |

9. Birthplace Chestertown Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thos. H. Stewart
13. Birthplace Del.

MOTHER
14. Maiden Name Sarah Murphey
15. Birthplace Delaware

16 (a) Informant Edward Pr. Stewart Jr.
(b) Address 414 Stafford Ave. Wilmington Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 19/49 (month) (day) (year)
(c) Cemetery or crematory Chester Cemetery
Location Chestertown Md

18 (a) Funeral director John O. Mitchell Sons
(b) Address 19 E Eastern Place

19 (a) NOV 16 1949 (Date rec'd by registrar) Evelyn Williams Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1949 at 6½ M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1943 to Nov. 16, 1949 and that I last saw her alive on Nov. 16 1949

Immediate cause of death Coronary Occlusion

Due to Arteriosclerosis & Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration 6 weeks / 10 years

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Lewis M.D.
Address 1111 St. Paul St Date signed 11/16/49 D.

VS 8

94a

G79939

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

G79939 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Beulah E Tyler

2. DATE OF DEATH: 11 — 14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 27-11
D. STREET ADDRESS (If rural, give location): 4703 Kernwood Ave #12

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland general Hosp.

c. Length of stay in Baltimore: #5 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Dec. 11, 1898 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Resin Hammond | Sue Hammond |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Arthur F. Tyler - 4703 Kernwood Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro vascular ~~accident~~ (NB) ? — INTERVAL BETWEEN ONSET AND DEATH: 3 days?
DUE TO (Marked Arteriosclerosis & Ischemia

(B) Hypertensive cardio vascular disease — ?
DUE TO

(C) and Diabetes mellitus — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uremia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11 — 12, 1949 *to* 11 — 14, 1949 *that I last saw the deceased alive on* 11-14, 1949 *and that death occurred at* 11:22 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Margarita Louisa Candler M. D. | Md. general Hospital | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11 - 17 - 49 | Cedar Hill | Brooklyn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Carleton Williams, M.D. | John C. Mitchell & Sons, Inc. | 1900 Eutaw Place |

VS 150 NB. Autopsy 11-15-49 showed no evidence of gross hemorrhage or thrombosis but marked chronic arteriosclerosis & ischemia Margarita Louisa Candler 61

G79940

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

170

G79940

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH FRANCIS PHILLIPS

2. DATE OF DEATH: Nov. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: 36 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: DC
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): Midway Hall

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Col | Single | 11/25/23 | 25 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stenographer | State Dept. Wash, DC | Ga. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edmund Phillips | Carrie ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | ? | Records- US Marine Hospital, Balto, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) DUE TO | Carcinoma of the breast with metastasis to the liver | 18 mos. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Oct. 8, 1949 *to* Nov. 13, 1949, *that I last saw the deceased alive on* Nov. 13, 1949 *and that death occurred at* 2:45P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 11/19/49 | Detroit Memorial Cem. | Macomb, Co., Mich. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Charles R. Law, 802 Madison Ave. |

VS 150

50

G79941

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916.0 N-948.2

Registered No. G79941

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEONARD V. DICKE Jr.

2. DATE OF DEATH: November 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-07
D. STREET ADDRESS (If rural, give location): 1423 N. Gay Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 11/7/40 | 9 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | BALTO. MD. | |

13. FATHER'S NAME: LEONARD V. DICKE SR.

14. MOTHER'S MAIDEN NAME: PHYLLIS V. BERGER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | | |

17. INFORMANT — ADDRESS: Mrs L.V. Dicke Sr.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) 2nd & 3rd degree burns

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 1423 N. Gay Street 8/7 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-15-49 8:57 P. m | | House afire |

22. *I certify that I took charge of the remains described above, held an* Insp. & inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Royer M.D. | | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49 | Beth | E. North Ave Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams, M.D. | Medard J. Blight | 6009 Harford Rd |

VS 151

180

G79942

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79942

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Mrs. Minnie Schwartz
2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale
C. Length of stay in Baltimore: 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 3018 Chelsea Terrace

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 72 If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Hyman
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Jack Schwartz ADDRESS: 3802 Sonner Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis
DUE TO
(B) Coronary sclerosis
DUE TO
(C) General Arteriosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 16, 1948, to 11-16, 1949, *that I last saw the deceased alive on* 11-16, 1949, *and that death occurred at* 2:15 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jerome Joachim Blumberg M. D.
23B. ADDRESS: Levindale Range
23C. DATE SIGNED: 11-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-17-49
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, Town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

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G79943

G79943

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17 0 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cecil BERKMAN

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 16 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore # 15 15-12
D. STREET ADDRESS (If rural, give location): 3454 Park Heights Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 10-30-04 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Housework | Penna. | U.S.A. |

13. FATHER'S NAME: Herman

14. MOTHER'S MAIDEN NAME: Kay Levit

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ~~Address~~ ADDRESS |
|---|---|---|
| no | | Kay Levit 3454 Park Hgts Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of breast — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-15 1949 *to* 11-16 1949, *that I last saw the deceased alive on* 11-16, 1949, *and that death occurred at* 10 50 A. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ruth Boies M.D. | Sinai Hosp. | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-17-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 16 1949 | Huntington Williams M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

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G79944

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20.0

Registered No. G79944

1. NAME OF DECEASED (Type or Print): JOHN BERNARD SEITZ

2. DATE OF DEATH: NOV 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEM HOSPITAL

C. Length of stay in Baltimore: 65 YRS (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 15-09
D. STREET ADDRESS (If rural, give location): 3905 BATEMAN AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | NOV. 15, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| dist MANAGER | SAFE COMPANY | USA, MARYLAND | USA |

13. FATHER'S NAME: PLEASANT H. SEITZ

14. MOTHER'S MAIDEN NAME: KATHERINE EVANS

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 185-07-3554 | MRS. ELSIE SEITZ | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4PM 15 NOV, 1949, *to* 7 PM 15 NOV 1949, *that I last saw the deceased alive on* NOV 15, 1949, *and that death occurred at* 7 PM, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. F. Coyle M.D. | Union Memorial Hospital | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Greenmount Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

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G79945

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20,1

G79945

Registered No.

1. NAME OF DECEASED (Type or Print): BENJAMIN B. BARBER

2. DATE OF DEATH: Nov. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1700 Bolton St.

c. Length of stay in Baltimore: 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 14-01
D. STREET ADDRESS (If rural, give location): 1700 Bolton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 19, 1889 | 60 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Real Estate Broker | Real Estate | Philadelphia, Pa. | |

13. FATHER'S NAME: Benjamin B. Barber

14. MOTHER'S MAIDEN NAME: Miriam Say Butcher

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Helen M. Barber | 1700 Bolton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Heart Disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/13, 1949, *to* 11/15, 1949, *that I last saw the deceased alive on* 11/15, 1949, *and that death occurred at* 2PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J. Krol M. D. | 1501 Eutaw Pl | 11/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49 | Mt. Olivet Cem. | Frederick, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

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G79946

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

600.0

G79946 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA I. T. McCURDY

2. DATE OF DEATH 11/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 15-38

D. STREET ADDRESS (If rural, give location) 2803 Elsinore Ave #16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 7/11/99 | 50 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical nurse

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles M. Tickner

14. MOTHER'S MAIDEN NAME Anna Gunts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO no

17. INFORMANT Mrs. Fred Mengers ADDRESS 2809 Elsinor Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Pyelonephritis, bilateral

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/8 19 49 *to* 11/15 19 49, *that I last saw the deceased alive on* 11/15 19 49 *and that death occurred at* 10 45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE Charles J. Black Jr. M.D.

23B. ADDRESS Maryland General

23C. DATE SIGNED 11/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11/18/49

24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.

24D. LOCATION (City, town, or county) (State) Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 17 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS Balto., Md.

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Correct age is especially important. Typewriter preferred. Please write plainly with pen and ink.

G79947 Helen C. Lomp G79947

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

174 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen C. Lomp. | 2. DATE OF DEATH: 11/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. | B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-01
D. STREET ADDRESS (If rural, give location): 2820 Kentucky Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | widowed | Jan 4, 1894 | 55 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Cumberland, Md | USA |

13. FATHER'S NAME: James J. Johnson

14. MOTHER'S MAIDEN NAME: Anne McCoy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Self | As Above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Metastatic Carcinoma to brain — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Primary carcinoma of uterus ?

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 3 1949 *to* Nov. 15, 1949 *that I last saw the deceased alive on* Nov. 15, 1949, *and that death occurred at* 7:45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas W. May M. D. | Mercy Hosp. | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-18-49 | Holy Redeemer Cem | Belair Rd - Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | John C. Miller Inc. | 2435 E. Oliver St |

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G79948

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79948

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosalie Simpson

2. DATE OF DEATH: Nov. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Garrett
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakland, Md.
D. STREET ADDRESS (If rural, give location): Route 2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | W. Va. | |

13. FATHER'S NAME: A. W. Sines

14. MOTHER'S MAIDEN NAME: Esther Fike

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Hemorrhage | 1 hour |
| DUE TO (B) | Potent ductus arteriosus | Congenital |
| DUE TO (C) | Subacute bacterial endocarditis | 1 year |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/16/49 | Potent ductus arteriosus | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-4-, 1949 *to* 11-16-, 1949, *that I last saw the deceased alive on* 11-16-, 1949, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rutherford S. Ruffin Jr. M. D. | JOHNS HOPKINS HOSPITAL | 11/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/20/49 | Arom Cem | West Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | Charles P. Towell | 2427 Edmondson Ave |

VS 150

157E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

ES-128560 G79949 ✓ G79949

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marie Anna Hudson

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-07
D. STREET ADDRESS (If rural, give location): 331 S. Lehigh Street (24)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Sept. 19, 1910 | 39 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Michall Pehringer

14. MOTHER'S MAIDEN NAME: Eva

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION: 5-5-49, 9-13-49

19B. MAJOR FINDINGS OF OPERATION: Closed Thoracotomy — Left Open Thoracotomy

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-27 19 49 *to* 11-16 19 49, *that I last saw the deceased alive on* 11-16 19 49, *and that death occurred at* 12:01 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. A. Rogers M. D.

23B. ADDRESS: 4940 Eastern Avenue

23C. DATE SIGNED: 11-16-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 18-49

24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart

24D. LOCATION (City, town, or county) (State): German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John G. Connelly ADDRESS 3500 Bank St.

VS 150

13B

G79950 Outten ✓ G79950

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-05820 751 Registered No.

1. NAME OF DECEASED (Type or Print): Kay Ella Outten 751

2. DATE OF DEATH: November 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp

C. Length of stay in Baltimore: 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-05
D. STREET ADDRESS (If rural, give location): 2210 Gough St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | March 2, 1947 | — | 8 / 9 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George C Outten
14. MOTHER'S MAIDEN NAME: Jennie Myers
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: None
17. INFORMANT: George C. Outten ADDRESS: 2210 Gough Street Baltimore 21, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
DUE TO
(B) Meningomyelocele — 8 mos.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 9, 1949 *to* Nov 16, 1949, *that I last saw the deceased alive on* Nov 16, 1949, *and that death occurred at* 12 45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. Richard Ford M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 11/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/17/49.
24C. NAME OF CEMETERY OR CREMATORY: Salem Lutheran Cemetery
24D. LOCATION (City, town, or county) (State): Catonsville 28, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Easton Sons ADDRESS: Catonsville 28, Md.

VS 150

157a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79951

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E81 1:4

G79951

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): HORACE MILBOURNE SMALLWOOD N-805.0

2. DATE OF DEATH: November 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: 62 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 716 Meadowbrook Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | April 12, 1884 | 65 | 7 | 3 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Gardner
10B. KIND OF BUSINESS OR INDUSTRY: St. Timothy School
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Smallwood
14. MOTHER'S MAIDEN NAME: Kate R. Espey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 218-18-7793
17. INFORMANT: Bertha M. Smallwood ADDRESS: Catonsville Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Pound Ventilus
DUE TO
(B) Rupture of Liver
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Catonsville, Maryland Route #40, ¼ mi. west of Rolling Rd.,
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-15-49 5:50 P m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L. Voss M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED: 11-16-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49. | London Park Cemetery | Baltimore, Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Easton Sons, Catonsville 28, Md.

VS 151

170C

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79952

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79952 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louise Schubert

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4515 Harford Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 4515 Harford Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | widowed | Sept 1-1855 | 94 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Hanover, Germany | |

13. FATHER'S NAME: Wilhelm Von Dollenberg

14. MOTHER'S MAIDEN NAME: Wilhelmina

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Mina Blanckard | 4516 Harford |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart Dis. | 5 yrs. |
| DUE TO (B) | Arteriosclerosis (Hypertension) | 10 yrs. |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic nephritis | 5 yrs. |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 10, 1947, *to* Nov. 16, 1949, *that I last saw the deceased alive on* Nov 15, 1949, *and that death occurred at* 9:10 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George Denegre M. D. | 4808 Harford Rd. | 11/16/49 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-18-49 | Maryland Park | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | Leonard J. Leuck | 5305 Harford |

VS 150

131a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79953

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G79953

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Henry Nelson Schwinn

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5604 Hamlet Ave

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 27-06
D. STREET ADDRESS (If rural, give location): 5604 Hamlet Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb 13-1914 | 35 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Linotype Operator | | Baltimore Md. | |

13. FATHER'S NAME: Henry L. Schwinn
14. MOTHER'S MAIDEN NAME: Grace Bates

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 213-03-3123 | Mrs. Dorothy Schwinn | 5604 Hamlet |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary occlusion | 1½ hr |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Coronary artery disease | 3 years |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Gastro-enteritis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 3, 1946, *to* Nov. 17, 1949, *that I last saw the deceased alive on* Nov. 17, 1949 *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ronald Jandorf M.D. | 6077 Harford Rd | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Woodland Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | OF FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | Leonard J. Luck. | 5305 Harford |

VS 150

94a

G79954

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

581.0

G79954

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stella Mae Watson

2. DATE OF DEATH: Nov. 15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 64xx Belair Rd

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 22-05

D. STREET ADDRESS (If rural, give location): 64xx Belair Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

Length of stay in Baltimore: — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W. | Married | Mar 22, 1896 | 52 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Reynolds

14. MOTHER'S MAIDEN NAME: Mary Rice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of the Liver — INTERVAL BETWEEN ONSET AND DEATH: 10 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive Heart Disease — 10 yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 25, 1949 *to* Nov. 14, 1949, *that I last saw the deceased alive on* Nov 14, 1949 *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Adam G Lewis M.D. | 6232 Belair Rd | Nov. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11/18/49 | New Cath | Balto. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | L. HECKMANN & SON | 6087 HARFORD 24 |

VS 150

1242

G79955

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4201

Registered No. G79955

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Frye House

2. DATE OF DEATH: Nov 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1615 Mulliken Court

C. Length of stay in Baltimore: Yrs. 70 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 1615 Mulliken Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C. | Widow | May 11 1864 | 85 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Charlottesville Va. | |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Luther Frye | 559 Baker St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

DUE TO

(B) Hypertension — "

DUE TO

(C) Arteriosclerosis — "

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 5, 1949 *to* Nov 14, 1949 *that I last saw the deceased alive on* Nov 5, 1949 *and that death occurred at* 4.00 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. W. McDaniel M.D. | 800 N Carrollton Av | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 19 49 | Arbutus M. Park | Arbutus Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | Mrs Robert G. Elliott Daughter | 94a 1129 N. Carrollton St. |

VS 150

G79956

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79956

Registered No.

1. NAME OF DECEASED (Type or Print): DOROTHY ROSE KANE

2. DATE OF DEATH: Nov. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2714 Riggs Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4307 Clifton Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Feb. 13, 1916 | 33 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School teacher (rtd) | | Balto., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Human A. Knoop | Julia Keating |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mr. George W. Kane | 4307 Clifton Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Adenocarcinoma of liver | 10 Aug '49 to 15 Nov. '49 |
| DUE TO (B) | Probably metastatic from primary Ca. large intestine | |
| DUE TO (C) | Complicating pregnancy. | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | none | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Aug. 1949. | Adenocarcinoma of liver (biopsy) | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10 Aug. 1949 *to* 15 Nov. 1949 *that I last saw the deceased alive on* 15 Nov. 1949 *and that death occurred at* 6:40 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph E. Muse Jr. M. D. | 5 West 29th St. | 16 Nov. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46E

Correct age if especially important. Physician: please write the cause of death clearly and legibly.

G79957

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79957

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMMA CATHELL KIDD

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH: A. Baltimore City, Maryland —

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for Women of Md

Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 18
D. STREET ADDRESS (If rural, give location): Ambassador Apts. 12-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | widow | Feb. 9, 1877 | 72 | 9 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Maryland | U.S. |

13. FATHER'S NAME: Dr. D. W. Cathell

14. MOTHER'S MAIDEN NAME: Jannett Boult

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Mr. J. Jackson Kidd, Jr. | 110 Castlewood Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 13 days

DUE TO

(B) Arteriosclerotic Heart Disease — 5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 4, 1949 *to* Nov. 16, 1949, *that I last saw the deceased alive on* Nov. 14, 1949, *and that death occurred at* 3:50 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John R. Smith, Jr. M. D. | Hosp. for Women of Md. Balto. 11, Md. | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Druid Ridge Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS, | Balto., Md. |

VS 150

93D

correct age is especially important. Physician: please write the cause of death clearly in ink.

G79958
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

587 Registered No. G79958

1. NAME OF DECEASED (Type or Print): WALTER PURNELL
2. DATE OF DEATH: November 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Parkville
D. STREET ADDRESS (If rural, give location): 3000 Texas Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Jan. 11, 1914 | 35 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pilot - ship | Boat | Norfolk, Va. | |

13. FATHER'S NAME: Walter Purnell, Sr.
14. MOTHER'S MAIDEN NAME: Mary E. ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes World War No. 2 | | Mrs. Consuelo Purnell | 3000 Texas Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypoglycemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute hemorrhagic necrosis of the pancreas

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Rogers M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-17-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/17/49 | | Norfolk, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Hunter Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

128

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79959

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

G79959 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Wilfred A. DeSonier

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1416 Linden Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1416 Linden Ave 14-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9/21/1891
9. AGE (In years last birthday): 58 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Fall River Mass.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown): No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 083-17-1954
17. INFORMANT: Ruben C. DeSonier — ADDRESS: 1416 Linden Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease with

DUE TO Chronic Myocardial Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 yrs.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: Nov. 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 11/19/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Pott & B. M. Walker — ADDRESS: Preston St.

VS 151

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79960

M S 131260

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20-0

G79960

Registered No.

1. NAME OF DECEASED (Type or Print): Henry J. Ruppel

2. DATE OF DEATH: 11-16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 127 W. Lee St. 22-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Sep. | Sept. 14, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: (D)

14. MOTHER'S MAIDEN NAME: (D)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Records B.C.H. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart Disease | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8-22- , 1949 , *to* 11-16- , 1949 , *that I last saw the deceased alive on* 11-16- , 1949 , *and that death occurred at* 7.10 AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. S. Cogan M. D. | 4940 Eastern Ave. | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-19-1949 | Cedar Hill | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | Flynn & Fleming 1426 Light St. |

VS 150

937

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79961

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 97-7 N-99.0

Registered No. G79961

1. NAME OF DECEASED (Type or Print): ELEANOR CHILDERS CHILDRESS

2. DATE OF DEATH: November 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: 42 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-05
D. STREET ADDRESS (If rural, give location): 108 Jackson Square

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Divorced | Oct 25 1905 | 44 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | At Home | Poland | U.S.A. |

13. FATHER'S NAME: Anthony Symanowicz

14. MOTHER'S MAIDEN NAME: Anna ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ---- | None | Mary Sauer | 3001 E Baltimore St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fluoride poisoning — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): unknown

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): unknown

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-15-49 Approx. 4:00 P m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Patient stated she had ingested poison identified as roach powder

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]

23C. DATE SIGNED: 11-16-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 17 1949 | Holy Cross Polish Cem | German Hill Rd Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Deffebach Bros. ADDRESS: 1800 E Lombard St

VS 151

1639

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79962
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 2 2 1

G79962
Registered No.

1. NAME OF DECEASED (Type or Print): BERNARD REINHARDT

2. DATE OF DEATH: November 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3616 Second Street, Brooklyn
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn 25-04
D. STREET ADDRESS (If rural, give location): 3616 Second Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | D | 3/27/1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waiter | Restaurant | Baltimore | |

13. FATHER'S NAME: George L. Reinhardt

14. MOTHER'S MAIDEN NAME: Katherine Adolph

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Family | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Delerium Tremens
DUE TO
(B) Chronic alcoholism
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-16-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 11/19/49 | Cedar Hill | Brooklyn |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, MD | Lee Funeral | - 130 E. Fort Ave |

VS 151

77D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79963

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. — Registered No. G79963

1. NAME OF DECEASED (Type or Print): Robert Woodruff
2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 1025 W. Lexington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | C | Single | Jan. 1, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Prince George Co. Virginia | U.S.A. |

13. FATHER'S NAME: Douglas Woodruff
14. MOTHER'S MAIDEN NAME: Susan Hawthorne

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Douglas Woodruff — ADDRESS: Hyattsville, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary Embolism | |
| DUE TO (B) | Cerebral vascular accident & left sided hemiplegia | |
| DUE TO (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 10-30 19 49 *to* 11-16 19 49, *that I last saw the deceased alive on* 11-16 19 49 *and that death occurred at* 5:30 a.m. *from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | [signature] | 11-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-17-1949 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 17 1949 | Huntington Williams, M.D. | Mrs. Katie R. Williams — 322 N. Schroeder St. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

83a

G79964

✓ Calhoun St.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

61

Registered No. G79964

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES BLUNT

2. DATE OF DEATH 11/14/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIV. HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 19-02
D. STREET ADDRESS (If rural, give location) 217 N. CALHOUN ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | COLORED | WIDOWED | 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | ? | ? | U.S. |

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | ? | ? |

17. INFORMANT Jeanette Jordan ADDRESS 217 N. Calhoun St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARCINOMA OF LARYNX — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/9/49 | CA OF LARYNX | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/5/49, *to* 11/14/49, *that I last saw the deceased alive on* 11/14/49, *and that death occurred at* 9:30 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Bachman M.D. | UNIV. HOSPITAL | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-19-1949 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Thurlington Williams, M.D. | Mrs. Katie R. Williams | 322 N. Schroeder St |

VS 150

47a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79965

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79965

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel William Shank

2. DATE OF DEATH: 11/16/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Sanitorium

c. Length of stay in Baltimore: Yrs. NINE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore - Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1800 N. Charles Street 12-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 11-10-1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Shank | Barbara |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 204-03-2898 | Mrs. Mary E. Shank | 1800 N. Charles St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis with Cerebral manifestations — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Peritonitis - Cause not certain — DAYS

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 3/5/49, 19 , to 11/16, 1949 that I last saw the deceased alive on 11/16, 1949, and that death occurred at 9:50 P.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M.D. | 2330 W. Fayette St | 11/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/19/49 | Greenhill Cem. | Waynesboro, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington Williams, MD | Wm. J. TICKNOR & SONS | Balto., Md. |

VS 150

97

G79966

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79966

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Esther Korman

2. DATE OF DEATH: Nov 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3200 Chelesa Terrace
c. Length of stay in Baltimore: 29 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 3200 Chelesa Terrace

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months: Days | If Under 24 Hours Hours: Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Morris Rudick

14. MOTHER'S MAIDEN NAME: Sarah ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Leizer Korman ADDRESS: 3200 Chelesa Terrace

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Accident (2nd attack) — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

DUE TO

(B) Hypertension — 5-6 years
Asthmatic Bronchitis — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1947 *to* 11/17 1949, *that I last saw the deceased alive on* 11/16 1949, *and that death occurred at* 5:00 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maurice Cooper MD M.D. | 2201 Eutaw Place | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 18, 1949 | Beth Tfiloh Cemetery | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS: 1126 W North Ave

VS 150

839

Correct age is especially important. Physician: please write the entire date clearly and legibly.

G79967

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 429.8 G79967 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Massey N-990

2. DATE OF DEATH: Nov. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Found floating at Pennsylvannia railroad Pier #6, Clinton St.
C. Length of stay in Baltimore: 15 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 415 S. Dallas St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Married | Sept. 19. 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Barge Co. | Viginia | U.S.A. |

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Rosa Massey | 415 S. Dallas St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Asphyxia due to drowning

DUE TO (B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) Acute Alcoholism

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Harbor

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Clinton St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Found drowned ? m

21E. INJURY OCCURRED WHILE AT WORK [?] NOT WHILE AT WORK [?]

21F. HOW DID INJURY OCoccur? ~~Found floating at Pa. R.R. Pier #6~~ Found drowned 26/6

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23A. SIGNATURE: W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Nov. 12, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II-17-1949 | Mt Calvery Cem. | Brooklyn A.A.Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Tunstington Williams, M.D. | Elroy O. Wilson | 1000 Brantly Ave. |

VS 151

183

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79968

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79968

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Vonnie Vera Hutchins

2. DATE OF DEATH: November 14, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1374 W. Stricker St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 1374 W. Stricker St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-01
D. STREET ADDRESS (If rural, give location): 1374 W. Stricker St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | W | June 30, 1 | 0 03 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Md. | U. S. A. |

13. FATHER'S NAME: John Marshall

14. MOTHER'S MAIDEN NAME: Ida Turner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Chas. Griffin | 1374 W. Stricker St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

Essential Hypertension + Arteriosclerosis

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH: year

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from June, 1949, to Nov 14, 1949, that I last saw the deceased alive on Nov 12, 1949, and that death occurred at 10 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samson R Julian M. D. | 1207 Madison Ave | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/18/49 | Charlotte Hall | Chas. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 17 1949 | Huntington for Williams, MD | Jos. S. Kelly | 1303 Presstman St. |

VS 150

83B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79969 X ✓ H.O G79969

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. ENNICE POLLARD

2. DATE OF DEATH: Nov 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
C. Length of stay in Baltimore: UNK. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PARKTON
D. STREET ADDRESS (If rural, give location): —

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | AUG 18, 1895 | 54 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE - (HSEWFE)
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): NO. CAROLINA
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: JOHN McMILLAN
14. MOTHER'S MAIDEN NAME: LUCINDA TAYLOR
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.:
17. INFORMANT: CLARENCE E. MATHENS — ADDRESS: PARKTON, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE LYMPHATIC LEUKEMIA — INTERVAL BETWEEN ONSET AND DEATH: +2 YRS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| NONE | NONE | YES ✓ NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* NOV 6, 1949, *to* NOV 17, 1949, *that I last saw the deceased alive on* NOV 17, 1949, *and that death occurred at* 9:20 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H. Wood M. D. | Union Memorial Hospital | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 20-49 | Wise Cemetery | Parkton, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 17 1949
REGISTRAR'S SIGNATURE: Evelyn Williams
25. FUNERAL DIRECTOR — ADDRESS: Howard S. Mashburn, White Hall, Md.

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

74a

B-353478
C79970

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

754 + C79970 Registered No.

BIRTH NO. 49-69247

1. NAME OF DECEASED (Type or Print): Ronald McKinney

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 519 N. Arlington Ave. 18-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | Negro | Single | April 19-1949 | | 6 | 27 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant | | Maryland | |

13. FATHER'S NAME: John McKinney

14. MOTHER'S MAIDEN NAME: Leola McKinney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) idiopathic hypertrophy of the heart

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 11-15- , 1949, *to* 11-16- , 1949 *that I last saw the deceased alive on* 11-16- , 1949, *and that death occurred at* 5.35 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Baltimore City Hospitals | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 16 1949 | Arbutus Mem. Park | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1601 Druid Hill Ave. |

VS 150

95c

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79971

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

175

G79971

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): MARIA JUSTINA SMITH

2. DATE OF DEATH: Nov. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1729 McCulloh Street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1729 McCulloh Street 14-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (write) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | ~~Single~~ divorced | Aug. 13, 1905 | 44 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Teacher | Public school | Baltimore Co. Md. | U.S.A. |

13. FATHER'S NAME: Frank Morris

14. MOTHER'S MAIDEN NAME: Agnes Douglas

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | None | Mrs. Marcelia Smith | 1729 McCulloh Street |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | papillary cystadeno-carcinoma of ovary | about 2 yrs |
| DUE TO | adenomyosis of uterus | |
| (B) | | |
| DUE TO | | |
| (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10.29.48 | as above | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/18, 1948 *to* 11/15, 1949, *that I last saw the deceased alive on* 11/15, 1949 *and that death occurred at* 3:45 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] | RAYMER F. PRESSMAN, M. D. 1000 EAST MADISON ST. BALTIMORE | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 18, 1949 | Arbutus Memorial Pk. | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

48 B

G79972

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79972

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA GOODMAN

2. DATE OF DEATH: 11/17/49

3. PLACE OF DEATH: Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2658 Park Heights Terrace

c. Length of stay in Baltimore: 14 Yrs. ~~Mos.~~ ~~Days~~

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH:
9. AGE (In years last birthday): 62? If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Solomon
14. MOTHER'S MAIDEN NAME: Sulatta

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Philip Goodman ADDRESS: 2658 Park Heights Ter

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarct

DUE TO

ANTECEDENT CAUSES

(B) Coronary atherosclerosis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/15, 1949 *to* 11/17, 1949 *that I last saw the deceased alive on* 11/17, 1949, *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walton Brahier M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 11/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-18-49
24C. NAME OF CEMETERY OR CREMATORY: Adas Israel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

61

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79973

BIRTH NO. 49-24145

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79973

1. NAME OF DECEASED (Type or Print): Baby Boy STREJCEK

2. DATE OF DEATH: Nov. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Volunteers of America Hosp.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto (2)
D. STREET ADDRESS (If rural, give location): 1223 N. Calvert St. 11-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | Nov. 12, 1949 | | 1 | 10 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto, Md. | |

13. FATHER'S NAME: Joseph Robert Strejcek

14. MOTHER'S MAIDEN NAME: Margaret Cheveral

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ND | | | Margaret Strejcek | 1223 N. Calvert St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

DUE TO

(B) Prematurity (30 weeks)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 12, 1949, *to* Nov 13, 1949, *that I last saw the deceased alive on* Nov 12, 1949, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Yaffe M. D. | Volunteers of America Hosp. | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | BALTIMORE MEDICAL SCHOOL NOV 15 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Hunter Jones Williams, M.D. | Commissioner of Health | |

VS 150

159

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79974

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

776 G79974 Registered No.

BIRTH NO. 49-24135

1. NAME OF DECEASED (Type or Print) Baby Boy Watkins.

2. DATE OF DEATH 11/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 315 N. Stricker St. ~~Redwood & Green Sts.~~ Balto. 19-01

c. Length of stay in Baltimore 8hr 27m (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 315 N. Stricker St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | c | | 11/9/49 | | | 8 / 27 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | University Hosp. Md | U.S. |

13. FATHER'S NAME Unknown.

14. MOTHER'S MAIDEN NAME Louise Watkins.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9 Nov 8 am 1949, to 9 Nov 4 30 pm 1949, *that I last saw the deceased alive on* 9 Nov, 1949, *and that death occurred at* 4 38 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Blackburn S. Joslin M.D. | Uni Hosp. Redwood & Green | 9 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL | NOV 15 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

159

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79975

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79975

BIRTH NO. 49-24165

1. NAME OF DECEASED (Type or Print): Baby Hill

2. DATE OF DEATH: Nov. 7 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hosp. for the Women of Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for the Women of Maryland

C. Length of stay in Baltimore: 7hrs 2 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Towson
D. STREET ADDRESS (If rural, give location): 9610 Willow Oak Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Nov. 7, 1949 | | | | 7 | 2 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Mr. Kenneth Miller Hill

14. MOTHER'S MAIDEN NAME: Evelyn Foster

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Mother | 9610 Willow Oak Towson Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 7 hours 2 min.

DUE TO

(B) Atelectasis, bilat

DUE TO

(C) Prematurity, extreme

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| — | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Nov. 7, 1949 *to* Nov. 7, 1949 *that I last saw the deceased alive on* Nov. 7, 1949, *and that death occurred at* 10:00 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Spencer, Jr. M.D. | Hosp. for Women of Maryland | 11/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | John Hopkins Medical School | NOV 14 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G79976

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79976

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY R. GRAY

2. DATE OF DEATH: 11/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 216 S. Green st

c. Length of stay in Baltimore: 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 216 S. Green st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col | married | Jan 20 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | Housework | Richmond Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Rich | Martha Veney |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Florence Wood | 849 Chase st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

(B) Chronic Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 4 1949 *to* Nov 14 1949 *that I last saw the deceased alive on* Nov 14, 1949, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Saunders M. D. | 122 W Lee st | 11/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Farnham | Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | D. L. Brown & Son | 108 W Montgomery St |

VS 150

correct age is especially important. Physician: please write the cause of death clearly and legibly.

108

G799'49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G799'49

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Groshans

2. DATE OF DEATH: Nov. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 107 East 33rd Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 107 East 33rd Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Sept. 12, 1859 | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| --- | | Baltimore, Maryland | |

13. FATHER'S NAME: Charles Kansler

14. MOTHER'S MAIDEN NAME: Anna Zopback

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| --- | | |

17. INFORMANT — ADDRESS: Fannie Kansler, 107 East 33rd Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 10 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ✓

DUE TO

(C) ✓

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ✓

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | ✓ | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan. 10, 1949 *to* Nov. 16, 1949 *that I last saw the deceased alive on* Nov. 16, 1949 *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank M. Ogden, M. D. | 2701 N. Calvert St | Nov. 17, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/19/49 | Druid Ridge Cemetery | Pikesville, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

VS 150

93D

Cause of death is especially important. Physician: please write the cause of death clearly and legibly.

AB-71800

779978

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 779978

1. NAME OF DECEASED (Type or Print): Albert Hasselback

2. DATE OF DEATH: 11-16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 53yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1923 E.Pratt St. 2-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | widowed | May 8- 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| UNKNOWN | UNKNOWN | Germany | |

13. FATHER'S NAME: Frederick Hasselback

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infraction
DUE TO
(B) Hypertensive arteriosclerotic heart disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 2-12- , 19 42 *to* 11-16 , 19 49 *that I last saw the deceased alive on* 11-16 , 19 49 , *and that death occurred at* 9.26 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Baltimore City Hospitals | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/18/49 | Moreland Park Cemetery | Parkville, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

US 150

93D

Collect age is especially important. Physician: please write the cause of death clearly and legibly.

G79979

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79979

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Morris Burns 2443

2. DATE OF DEATH 10/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Penna. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Philadelphia

D. STREET ADDRESS (If rural, give location) UNKNOWN

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Colored | Single | | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| UNKNOWN | UNKNOWN | Baltimore, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Burns | Rebecca Burns (Maiden Name) UNKNOWN |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Niece ADDRESS |
|---|---|---|
| No. | | Miss Burns 1524 May Court |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Probable Hypertensive Encephalopathy DUE TO

(B) Hypertensive Cardio-Vascular Disease. DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY

for: C. J. Lubinski, M. D.

CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/20/49, 19__, *to* 10/31/49, 19__, *that I last saw the deceased alive on* 10/31, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John Romanello M. D. | Mercy Hospital | 11/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

UNIVERSITY MEDICAL SCHOOL NOV 11 1949

DATE RECEIVED BY LOCAL REGISTRAR NOV 18 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

DIRECTOR OF HEALTH Commissioner of Health

ADDRESS

VS 150

Body released by Medical Examiner 93D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79980

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 916.0

Registered No. G79980

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD WEBSTER N 968.0

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Shack at foot of Briscoe St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | U | U | 53 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | K | |

13. FATHER'S NAME: N O

14. MOTHER'S MAIDEN NAME: O

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to

DUE TO

(B) inhalation of smoke (carbon monoxide poisoning)

DUE TO

(C) (open)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Shack at foot of Briscoe St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 3, 1949 12:30 A. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCoccur? Shack afire

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 3, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 11 1949 | |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS

VS 151

180

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79981

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79981 Registered No.

1. NAME OF DECEASED (Type or Print) William Smith Chambers

2. DATE OF DEATH Nov. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Mount Nursing Home

C. Length of stay in Baltimore 59 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY Briarstone Rd. Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Randallstown Md.
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 21, 1878 | 71 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cemetery Supt.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Newville Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME W. Paris Chambers

14. MOTHER'S MAIDEN NAME Anne Drawbaugh

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Hilda Millar Chambers ADDRESS Briarstone Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Hemiplegia, left — 4 months

DUE TO

(C) Cerebral Thrombosis — 4 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis, Generalized — ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1949, *to* Nov. 15, 1949, *that I last saw the deceased alive on* Nov 11, 1949, *and that death occurred at* 5 0 m., *from the causes and on the date stated above.*

23A. SIGNATURE Lyle O. Leaphart M. D.

23B. ADDRESS Medical Art Bldg

23C. DATE SIGNED Nov. 18 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Nov. 18, 49

24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery

24D. LOCATION (City, town, or county) Balto. Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 18 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Ellsworth Amacker

ADDRESS 5218 Gwynn Oak Ave.

VS 150

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79982

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 40 1

G79982 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Leroy Artis

2. DATE OF DEATH 11/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) Unknown 4-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | B | ? | ? | 45 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | | ? | |

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ? ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Meningitis & Pneumonia

DUE TO

(B) Septicemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Cellulitis Left leg.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-9-49 19 , *to* 11-12-49, 19 , *that I last saw the deceased alive on* 11-13-49 19 , *and that death occurred at* 2 39 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| O. Helms M. D. | University Hosp | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 17 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Thomas [illegible] Baltimore, Md | Commissioner of Health | 811 |

VS 150 Picked up on street by police and conscious - Police unable to locate relatives

AB-127918

G79983

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79983

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia Saunders

2. DATE OF DEATH: 11-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 52 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 324 W. Preston St. 11-04

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 14- 1870
9. AGE (In years last birthday): 79 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Saunders
14. MOTHER'S MAIDEN NAME: Rosanna (Rosenna)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Arteriosclerotic cardiovascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Non-specific ulcer of mouth

19A. DATE OF OPERATION: 10-28-1949
19B. MAJOR FINDINGS OF OPERATION: Biopsy of mouth lesion (ulcer)
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-31- , 1949 *to* 11-8- , 1949, *that I last saw the deceased alive on* 11-8- , 1949, *and that death occurred at* 1P *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. L. Rogers M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL NOV 17 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

AB-130008
~~79984~~

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79984

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Whitmore

2. DATE OF DEATH: 11-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 2yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 725 Dover St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Married | Jan. 6- 1918 | 31 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elijah Whitmore
14. MOTHER'S MAIDEN NAME: Daisy Snaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Records: ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Tuberculous meningitis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Miliary tuberculosis | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-30- , 1949 *to* 11-8- , 1949 *that I last saw the deceased alive on* 11-8 , 1949 *and that death occurred at* 7.40 pm *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-16-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL NOV 17 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

130

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr Feaney
G79985
3025 Belair

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79985
Registered No. 43

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Peter Moore
2. DATE OF DEATH: Nov. 16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4825 Frankford Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-02
D. STREET ADDRESS (If rural, give location): 4825 Frankford Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Oct. 31-1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired FIREMAN | County | Hungary | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Moore | Elizbeth Shade |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Alma Moore | 4825 Frankford |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Renal Disease with Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) — 1 year

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 1949 *to* 11-16, 1949 *that I last saw the deceased alive on* 11-16, 1949, *and that death occurred at* 11:45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wilbur L. Feaney, M.D. | 3025 Belair Road | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 11-19-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Leonard J Luck - 5305 | Harford |

VS 150

93)

Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

G79988

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79988 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Drury L. Morris

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 1708 Eutaw Place

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 823 Eutaw Place 11-03

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmhurst Nursing Home.

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Oct. 11, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired LABORER | | Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William | not known |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 212-12-9111 | Rev. R. D. Balderson | 3104 Rockwood Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilation — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Cardiac Renal Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/15, 1949 *to* 11/17, 1949, *that I last saw the deceased alive on* 11/17, 1949, *and that death occurred at* 4 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2320 Eutaw Pl | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Loudon Park | Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Clarence F. Hoffmann | 1639 Broadway. |

VS 150

131a

Please write clearly and legibly. Physician: please write the cause of death clearly and correct age is especially important.

G79987

CERTIFICATE CORRECTED 11-21-49

G79987

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151 Registered No.

BIRTH NO. (Sewall B. Brown)

1. NAME OF DECEASED (Type or Print) Sewall B. Brown

2. DATE OF DEATH Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2710 Parkwood Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2710 Parkwood Ave. 13-24

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Mar. 6, 1864 | 85 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired owner | restaurant | Balto., Md. | |

13. FATHER'S NAME - George Allen Brown

14. MOTHER'S MAIDEN NAME - Julia Taylor

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | | | Mrs. Lula Brown | 2710 Parkwood Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Stomach (Carcinoma ventriculi)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Abdominal Aneurism

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 8, 1949 *to* Nov. 6, 1949, *that I last saw the deceased alive on* Nov. 6, 1949, *and that death occurred at* 2:20 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Dr. David I. Wolff M. D. M. D. | 3420 Auchentoroly Ter. | Nov 18 1949. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Entombment | 11/19/49 | Lorraine Mausoleum | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46 B

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79988

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79988

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | RICKA REINHARDT |
| 2. DATE OF DEATH | Nov. 16, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | Harford Convalescent Home 4700 Harford Rd. |
| c. Length of stay in Baltimore | Yrs. Mos. Days |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | Baltimore |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 8219 Belair Rd. |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widow |
| 8. DATE OF BIRTH | Feb. 10, 1858 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min. | 91 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | own home |
| 11. BIRTHPLACE (State or foreign country) | Germany |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | William Kuethe |
| 14. MOTHER'S MAIDEN NAME | Fredericka Gremesen |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) / (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO | no |
| 17. INFORMANT / ADDRESS | Mr. William Reinhardt - Fullerton, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | MYOCARDIAL DEGENERATION | 10 YRS. |
| DUE TO (B) | SENILITY | 10 YRS. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | ARTERIOSCLEROSIS | 10 YRS. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | SENILE DEMENTIA | 1 YR. |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* NOV. 3, 1949 *to* NOV. 16, 1949 *that I last saw the deceased alive on* Nov. 15 1949 *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
| H. W. Machen M. D. | 6331 Belair Road (6) | 11/17/49 |

| | | | |
|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
| Burial | 11/19/49 | Cedar Hill Cem. | Balto., Md. |

| | | |
|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR / ADDRESS |
| NOV 18 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

VS 150

937

Please write plainly, with ink. Use no abbreviations. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G79989

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 0 G79989 Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | ANNETTE HALE RATH |
| 2. DATE OF DEATH | Nov. 17, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 303 Northway | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore |
| c. Length of stay in Baltimore 50 yrs. (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location) 303 Northway 77-11 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| female | white | married | Nov. 1, 1881 | 68 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | N. Y. State | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Hollis Hale | Adelaide Patterson |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Ridgely A. Frey | 303 Northway |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma right breast | 2 yr. |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| August 10 '49 | Carcinoma of breast | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 23, 19 49 *to* 11/17, 19 49, *that I last saw the deceased alive on* 10/28, 19 49, *and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. J. Battaglia M. D. | 5822 Belair Rd. | Nov. 17, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Hunter for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

50

G79990

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

57-1

Registered No. G79990

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EARL JAMES CULLEN

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospt.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Co - Annesley
D. STREET ADDRESS (If rural, give location): 704 ANNESLIE ROAD

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 1905
9. AGE (In years last birthday): 44
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OWNER - MGR.
10B. KIND OF BUSINESS OR INDUSTRY: TAVERN
11. BIRTHPLACE (State or foreign country): CRISFIELD MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES CULLEN
14. MOTHER'S MAIDEN NAME: MARY YOUNG.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MRS E. J. CULLEN - ADDRESS: 704 ANNESLIE RD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Hypertension C-V Dis.
DUE TO
(C) Polycystic Dis. of Kidneys

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 Yrs.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-15-, 19 49 to 11-16, 19 49, that I last saw the deceased alive on 11-16, 19 49, and that death occurred at 12:05 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Chas. B. Carr Jr. M. D.
23B. ADDRESS: 6007 York Road
23C. DATE SIGNED: 11/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11-19-49
24C. NAME OF CEMETERY OR CREMATORY: CATHEDRAL -
24D. LOCATION (City, town, or county) (State): CITY -

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD AND SON
ADDRESS: GREENMOUNT AVE. & 22nd ST.

VS 150

93D

PLEASE WRITE LEGIBLY. WITH UNFADING INK. Every item of information should be given. If any item is unknown, state so. Where date of birth is unknown, correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79991

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G79991

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Maresa Detering Shaffer

2. DATE OF DEATH 11/6/49

3. PLACE OF DEATH: A. Baltimore City, Maryland, 177 Fuetonard

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 21 B. COUNTY Dundalk Md Baltimore Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 21 Dundalk Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W. | Widow | 3/12/1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Baltimore Md | U.S. |

13. FATHER'S NAME Frederick Detering

14. MOTHER'S MAIDEN NAME Pauline Imvrad

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. C. Strauss | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: 9 mos.

DUE TO

(B) Senile Arteris Sclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 15, 1949 *to* Nov 16, 1949 *that I last saw the deceased alive on* Nov 16, 1949 *and that death occurred at* 6:30 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thos. J. Bubert M. D. | 4803 Park Heights Ave | 11/17/49 |

| 24A. BURIAL, CREMATORY, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Cathedral | 414 Fulton Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | J. J. Zahn & Sons | 94a |

VS 150

Physician please write the cause of death clearly and legibly. Correct age is especially important.

G79992

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20-0

G79992

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eleanor Simpson

2. DATE OF DEATH November 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1212 St. Paul St. 11-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 5-13-87 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Kentucky | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Simpson | Mary Harvey |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) shock + pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 d.

DUE TO

(B) Myocardial infarction — 2 weeks

DUE TO

(C) Hypertensive arteriosclerotic Heart Disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Raynaud's disease.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-10, 1949, to 11-15, 1949, *that I last saw the deceased alive on* 11-15, 1949, *and that death occurred at* 6.30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Evan Calkins M. D. | JOHNS HOPKINS HOSPITAL | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Forest Lawn | Reisterstown Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | J. Foley Sons 1308 Light |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G79993

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G79993 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward Seymor Parks

2. DATE OF DEATH 11/17/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

b. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sparks (Rural)
D. STREET ADDRESS (If rural, give location) York Rd

5. SEX M | 6. COLOR or RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 9/2/1881 | 9. AGE (In years last birthday) 68 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | 10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Parks

14. MOTHER'S MAIDEN NAME Emma J. Lee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None

17. INFORMANT Hosp. Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of rt. lung & metastasis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/15, 1949 *to* 11/17, 1949 *that I last saw the deceased alive on* 11/17, 1949 *and that death occurred at* 6.00 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE Robert L. Lucas M. D. | 23B. ADDRESS St. Agnes Hosp. | 23C. DATE SIGNED 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 11-20-49 | 24C. NAME OF CEMETERY OR CREMATORY Jessops | 24D. LOCATION (City, Town, or County) (State) Sparks, Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 18 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Landon M. Brooks | ADDRESS Sparks, Md

VS 150

479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physician: please write the cause of death clearly and legibly.

AB-130639

G79994

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G79994 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Cromwell

2. DATE OF DEATH: 11-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2001 Kelly Ave, Mt. Washington 27-15

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Married | Feb. 1- 1878 ? | 71-73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Cromwell
14. MOTHER'S MAIDEN NAME: Rosa Berry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Records: Baltimore City Hospitals, 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Hypertensive arteriosclerotic cardiovascular renal disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28- , 1949 *to* 11-16- , 1949 *that I last saw the deceased alive on* 11-16- 1949 *and that death occurred at* 7.50 PM *from the causes and on the date stated above.*

23A. SIGNATURE: G. L. Cogen M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/21/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Geo. O'Nelson
ADDRESS: 1303 Pressman St.

VS 150

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79995 X ✓ 80 G79995

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Milton W. Borgman, Sr.

2. DATE OF DEATH November 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ~~BALTIMORE~~ (Woodlawn)
D. STREET ADDRESS (If rural, give location) 2139 Lorraine Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 year: Months / Days | If Under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | July 14, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stone-Cutter | monuments | Baltimore, Maryland | U.S. |

13. FATHER'S NAME William Frederick BORGMAN
14. MOTHER'S MAIDEN NAME Lena BARTLING.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Milton W Borgman, Jr. | 2139 Lorraine Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cardio-respiratory Failure | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| November 10, 1949 | Hypernephroma - Right KIDNEY | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November 6 1949, *to* November 16 1949, *that I last saw the deceased alive on* November 16 1949, *and that death occurred at* 12 56 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Spittel, Jr. M. D. | Mercy Hospital | 11/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-19-1949 | Lorraine Park | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | [illegible] for Registrar | J. Howard Strong | 3207 W. North Ave |

VS 150

52a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79996

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G79996

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bonw Pearl Spamer

2. DATE OF DEATH: 11-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-09
D. STREET ADDRESS (If rural, give location): 4109 Alto Rd #16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 10-5-1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | md. | USA |

13. FATHER'S NAME: C. Augustas C. Spamer

14. MOTHER'S MAIDEN NAME: Abbie C. Smith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | None | Miss Lorie Mae Spamer | 4109 Alto Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO (B) Cerebro vascular accident ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) Arteriosclerotic cardiovascular disease — several years

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-13 1949 *to* 11-17 1949 *that I last saw the deceased alive on* 11-16 1949 *and that death occurred at* 5 08 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Lorian Cadle M. D. | Maryland General Cadle | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 11-21-1949 | Loudon Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | J. Howard Strong | 3207 W. North Ave |

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G79997 — BALTIMORE CITY HEALTH DEPARTMENT — E916.0 N966.0 — G79997

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Eugene F. (PHONIX) FINNEY (ajm)

2. DATE OF DEATH: Nov. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: 20 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Shack at foot of Briscoe St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Colored | Separated | 8/8/06 | 32 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed not known
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Spartanburg, S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Haines Finney
14. MOTHER'S MAIDEN NAME: Lula Finney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW-II
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Estelle Anderson — ADDRESS: 633 S. Paca St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to inhalation of smoke (carbon monoxide poisoning)

DUE TO

(B)

DUE TO

(C)

(over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Shack at foot of Briscoe St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 3, 1949 12:30 A.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Shack afire

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Geo. G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Nov. 3, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/18/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Charles R. Lee — ADDRESS: 802 Madison Ave

VS 151

180

G79998

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 ✓ Registered No. G79998

STATE FILE NO.

1. NAME OF DECEASED (Type or Print): Richard Carter.

2. DATE OF DEATH: 11-14-1949

3. PLACE OF DEATH:
A. Baltimore City. Maryland 112 Asquith St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): A. M. E. Aged Home. 112 Asquith St.

c. Length of stay in Baltimore: Over 50 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 112 Asquith St. ✓-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | C | Separated | March 21, 1855 | 94 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nora Carter.
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: A. M. E. Home Record 112 Asquith St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiorenal Renal complication with hypertension — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 1944 *to* May 14, 1949 *that I last saw the deceased alive on* May 14 1949 *and that death occurred at* 4:43 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. R. Stewart M.D.
23B. ADDRESS: 632 W Fayette St
23C. DATE SIGNED: May 16

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-18-1949
24C. NAME OF CEMETERY OR CREMATORY: W. Zion Cem.
24D. LOCATION (City, town, or county) (State): Lansdowne Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Walter R. Williams
ADDRESS: 522

VS 150

1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G79999
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Ver. 1 G79999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John B. Milburn
2. DATE OF DEATH: Nov. 16-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4703 Hamprett Ave. Pine Ridge Nursing Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-44
D. STREET ADDRESS (If rural, give location): 3217 Hamilton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Oct 12-1877 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired City
10B. KIND OF BUSINESS OR INDUSTRY: Laborer
11. BIRTHPLACE (State or foreign country): St. Marys Co. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John L. Milburn
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Edgar Milburn ADDRESS: 3217 Hamilton

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Chronic Myocarditis | Years |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1940, *to* 11/17, 1949, *that I last saw the deceased alive on* 11/16, 1949, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Rhew Dolley, M. D.
23B. ADDRESS: 5793 Reisterstown Rd
23C. DATE SIGNED: 11/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-19-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Keck ADDRESS: 5305 Reisterstown

VS 150

931

G80000

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80000

BIRTH NO. 49-24334

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Booz, Baby Girl

2. DATE OF DEATH: November 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Back River
D. STREET ADDRESS (If rural, give location): Edgewater Road

5. SEX: Fe.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 11/13/49
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 5 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/13/ , 1949, to , 19 , that I last saw the deceased alive on 11/13/ , 1949, and that death occurred at 6:00 P.M., from the causes and on the date stated above.

23A. SIGNATURE: Samuel Shrlich M. D.
23B. ADDRESS: 1100 N. Caroline Street
23C. DATE SIGNED: 11/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-19-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J Kuck
ADDRESS: 5305 Harford Rd

VS 150

161a

CERTIFICATE CORRECTED 2-14-50

G80001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80001

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CATHERINE ZOELLER

2. DATE OF DEATH 13 November, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hood Nursing Home

c. Length of stay in Baltimore About 8 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 409 N. Saratoga Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | June 1, 1872 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | home | Wurttemberg, Germany | U. S. |

13. FATHER'S NAME Abel

14. MOTHER'S MAIDEN NAME Rockendorffer Kochendoerffer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | None | hospital chart | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Heart failure | 2 months |
| DUE TO (B) | arteriosclerosis | years |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | fractured hip-healed — Decubitus ulcer | 2 mon |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY
B K Forbes M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| about 8 weeks ago | fractured hip | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home of niece | Pikesville |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| noon - Sunday, date ? m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | slipped on rug |

22. *I hereby certify that I attended the deceased from* Sept, 1949 *to* Nov, 1949 *that I last saw the deceased alive on* 13 Nov, 1949, *and that death occurred at* 1150 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Godman M.D. M. D. | 1324 Eutaw Pl. Balto. Md | 16 Oct 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV. 19 '49 | WESTERN | BALTO. MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Henry A Wilhelm | 401 EDMONDSON AVE |

VS 150

97

G80002

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH, 1949

Registered No. G80002

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ruth I. Denby

2. DATE OF DEATH: 11/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3240 Keswick Rd.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3240 Keswick Rd. 13 05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Dec 5, 1896 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lapper | Rosenau Chemical Co | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm H. Murnaw | Hattie Stump |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| — — | 218-03-1521 | Wm H. Murnaw 3240 Keswick Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of cervix — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

(B) Eurelum, anemia, DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/1 1949, to 11/15 1949, *that I last saw the deceased alive on* 11/15 1949, *and that death occurred at* 3:45 p. m., *from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A Calas M. D. | 47 Fulton | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/19/49 | Bridwood | Taylor Sta. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | [illegible] |

VS 150

48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the cause of death clearly and legibly.

680003

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680003

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Patsie Johnson Lightner

2. DATE OF DEATH: Nov 18 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Md; B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2003 E Preston St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. 13 yrs Mos. Days

D. STREET ADDRESS (If rural, give location): 2003 E Preston St. 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | Aug 5, 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | S. C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Allen Foster | Lithia McCraw |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Thomas Lightner | 2003 E Preston |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) adeno - Carcinoma - Mammary — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July 49 | adeno Carcinoma (breast) | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7/6 1949 *to* 11/16 1949 *that I last saw the deceased alive on* 11/14 1949 *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

RAYMER BROWNE, M.D. 1500 EAST MADISON ST. BALTIMORE, MD.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| | | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov 18/49 | | Winnsboro S. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Mrs Robert A. Elliott & Daughter | 1129 N. Caroline St. |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete. Cause of death clearly and legibly. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80003 ✓ Vol 053.1 G80004

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): James Brown

2. DATE OF DEATH: 11-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: 12 Yrs. (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1710 Orleans Street (31) 6-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | July 24, 1912 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Va | |

13. FATHER'S NAME: Dock Brown

14. MOTHER'S MAIDEN NAME: Nannie Turner ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: RECORDS BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ~~Sepis~~-acute bacterial endocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ~~Rheumatic heart disease~~ Staphylo-
DUE TO coccus albus, septicemia

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

over

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-8, 19 49, to 11-15, 19 49, *that I last saw the deceased alive on* 11-15 19 49, *and that death occurred at* 10:20 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Logan M. D.

23B. ADDRESS: 4940 Eastern Avenue

23C. DATE SIGNED: 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.

24D. LOCATION (City, town, or county) (State): B.C. County Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Mrs. Gott A. Elliott or Daughter

ADDRESS: 910 or 1129 N. Caroline St.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" or "Unknown" where necessary. Be sure that the cause of death clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80005

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80005 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERT LEE THOMPSON

2. DATE OF DEATH: November 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middle River DOWLEYS QUARTERS
D. STREET ADDRESS (If rural, give location): Route 16 Box 186

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | March 29, 1889 | 60 | 7 | 18 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Penn. R. R. | Baltimore Md. | |

13. FATHER'S NAME: Robert Lee Thompson

14. MOTHER'S MAIDEN NAME: Barbara Annie Roten

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| N. N. # 1 | | Irene Thompson | Above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive and arteriosclerotic heart disease | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Carl L. Reyer M.D. | | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 21-49 | Balto. National | Frederick Rd. - Balt. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Assistant Registrar | Thos. G. Connelly | Same |

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G80006

BIRTH NO. 49-24438

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

7544

G80006
Registered No.

1. NAME OF DECEASED (Type or Print): DENNIS B STICH

2. DATE OF DEATH: 11-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

c. Length of stay in Baltimore: 7 DAYS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALT. CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-24
D. STREET ADDRESS (If rural, give location): 141 S. CALVERTON ROAD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | INFANT | NOV. 10, 1949 | | 0 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| INFANT | — | MARYLAND | — |

13. FATHER'S NAME: JOSEPH STICH

14. MOTHER'S MAIDEN NAME: REGINA KELLER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | — | — | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ulcerations stomach

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-15, 1949 *to* 11-17, 1949 *that I last saw the deceased alive on* 11-17, 1949 *and that death occurred at* 2:25 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James A. Roberts M. D. | Mercy Hospital | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 19 Nov 49 | Mt. Cathedral | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | F. Bilgert & Son - J. Lee Fontaine | |

VS 150

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80007

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1700.1 G80007

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Eugene E. Betz

2. DATE OF DEATH Nov. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

c. Length of stay in Baltimore — Yrs: 3o Mos: — Days: —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland — B. COUNTY Balto. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Halethorpe
D STREET ADDRESS (If rural, give location) Brady — Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | May 2 1935 | 14 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At School. | At School. | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph A. Betz. | Nannie B. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Joseph W. Betz | - Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Lymphosarcoma — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lipodystrophy - Pituitary type

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/24/49 | Lymphosarcoma in abdomen | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/8/, 1949 *to* 11/17/, 1949 *that I last saw the deceased alive on* 11/17/, 1949, *and that death occurred at* 6:00 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. Shobler M. D. | Bon Secours Hosp | 11/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 21 Nov. 49 | Loudon Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | A. B. Wisbert & Son | 1300 Eutaw St |

VS 150

55E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; if none, so state. Be sure that the correct age is especially important. Physician: please write the cause of death clearly and legibly.

680008

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680008

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sister Thecla Bloomer ( Blomer)

2. DATE OF DEATH: 11-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute

c. Length of stay in Baltimore: 2 Yrs. 17 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: The Seton Institute
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 28-01
D. STREET ADDRESS (If rural, give location): 6420 Reisterstown Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | June 24, 1862 | 87 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SISTER | | Little Rock, Arkansas | U. S. A. |

13. FATHER'S NAME: James Bloomer

14. MOTHER'S MAIDEN NAME: Catherine Delaney

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Records Seton Institute | Balto. Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Arteriosclerosis Grad ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Psychosis with arteriosclerosis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 4/1 19 47 *to* 11/17 19 49 *that I last saw the deceased alive on* 11/17 19 49 *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Damian P. Algeo M. D. | 336 Bridgeland | 11/17/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 19 1949 | Seton Cemetery | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | Stewart & Mowen Co. | 108 W. North Ave. |

VS 150

94a City #1.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80009

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80009

1. NAME OF DECEASED (Type or Print) OVER, GEORGE

2. DATE OF DEATH Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital
c. Length of stay in Baltimore 3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson, Md.
D. STREET ADDRESS (If rural, give location) Goetz Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Dec. 7th, 1898 | 50 | 11 / 10 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY American Oil Co.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry W. Over
14. MOTHER'S MAIDEN NAME Margaret Rodgers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-01-4490
17. INFORMANT Mrs. G.F. Over ADDRESS Goetz Ave., Towson, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis. — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intra-luminal gastro-intestinal hemorrhage.

DUE TO

(C) Duodenal ulcer

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/18/49 *to* 11/17/49 *that I last saw the deceased alive on* 11/17, 1949 *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE R. Leonard Desser M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 11/17/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/21/49 | Baltimore | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR NOV 18 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Loacker Funeral Home ADDRESS 7401 Belair Rd.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given correct age is especially important. Physician: please write the cause of death clearly and legibly.

1178

G80010

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80010

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK (CATENCAMP) KATENKAMP

2. DATE OF DEATH: November 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 607 S. Hanover Street 22-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | widower | Jan. 30th, 1875 | 73 | 9 | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Rooming house operator | | Baltimore City, Md. | USA |

13. FATHER'S NAME: Francis D. Katenkamp

14. MOTHER'S MAIDEN NAME: Mary E. Hoffman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mr. Lloyd Ruhe | Silver Spring Rd. #603 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic Cardio-

DUE TO

(B) Vascular Disease -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Royer M.D. | | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/19/49 | Mt. Olivet | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Registrar for Baltimore, Md. | Lasasha Funeral Home | 7401 Belair Rd. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct ago is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

937

G8001 1 51 G8001

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Coster, Frank J

2. DATE OF DEATH: Nov. 17th, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fullerton, Md.
D. STREET ADDRESS (If rural, give location): Camp Chapel Rd.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General

c. Length of stay in Baltimore: Yrs. life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M | Sept. 18th, 1872 | 77 | 1 | 29 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | | Baltimore County, Md. | USA |

13. FATHER'S NAME: John Coster

14. MOTHER'S MAIDEN NAME: Ludwina Dentz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | | |

17. INFORMANT: Mrs. Frank J. Coster — ADDRESS: Camp Chapel Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of the Stomach | 6 mos + |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Pulmonary infarction, Left Lower lobe, Arteriosclerosis, generalized | 2 weeks 2 years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 10-20, 1949 *to* 11-17, 1949 *that I last saw the deceased alive on* 11-17, 1949, *and that death occurred at* 1:25 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marvin W. Davis M. D. | W. Balto. Gen. Hosp. | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/21/49 | St. Josephs | Fullerton, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949

REGISTRAR SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Rd.

VS 150

46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Physician: please write the cause of death clearly and legibly. correct age is especially important.

G80012 — G80012

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No. 443

1. NAME OF DECEASED (Type or Print): Loretta E. Dunn

2. DATE OF DEATH: Nov. 17/49

3. PLACE OF DEATH: a. Baltimore City, Maryland — Baltimore Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2336 W. Lexington St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2336 W. Lexington St. 20-02

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 16,1901
9. AGE (In years last birthday): 48 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: C. & P. Telephone Telephone Operator
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward V. Dunn
14. MOTHER'S MAIDEN NAME: Julia C. McGuirk

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs. Julia C. Dunn, 2336 W. Lexington St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease

DUE TO

(B) Cardiac decompensation

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 47 *to* Nov 17 49, *that I last saw the deceased alive on* Nov 17 49 *and that death occurred at* 2 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wayne Bayley M. D.
23B. ADDRESS: 2333 W North Ave
23C. DATE SIGNED: 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 19/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City or County) (State): Balto. Md.
ADDRESS: 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: NOV 18 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry W. Nuttle
ADDRESS: 4101 Edmondson Ave.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as age is especially important. Physicians: please write the cause of death clearly and legibly.

G80013

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

6.1 G80013

Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH DOTTERWEICH

2. DATE OF DEATH NOV. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 406 S. AUGUSTA AVE.
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 406 S. AUGUSTA AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year Months Days | If under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| F | W | W, D or W | NOV. 17, 1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Herman Schwallenberg | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Frank Dotterweich | 45, Yorktown |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic C. V. D. | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) Carcinoma of Liver | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* MAY, 1949, *to* NOV., 1949, *that I last saw the deceased alive on* NOV. 18, 1949, *and that death occurred at* 10 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3325 Frederick Ave | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Huntington Williams, M.D. | George A. Farley Funeral Dir. | Fayette St. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Please see that cause of death is correct age is especially important. Physician: please write the cause of death clearly and legibly.

46F

G80017

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54

Registered No. G80017

1. NAME OF DECEASED (Type or Print): JOHN G. SCHERBEL

2. DATE OF DEATH: NOV. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2707 Edmondson Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-SW
D. STREET ADDRESS (If rural, give location): 2707 W. Edmondson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Feb. 21, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Clerk | Saving & Loan Assn | Maryland | |

13. FATHER'S NAME: George Scherbel

14. MOTHER'S MAIDEN NAME: Annie Kinkel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | 216-07-1578 | Margaret C. Scherbel | 2707 Edmondson Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) myocardial failure
DUE TO
(B) malignancy of rectum c metastases to lung
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 2 days; (B); (C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1-8-49, 19__, *to* 11-16-49, *that I last saw the deceased alive on* 11-13, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry S. Trumbell M. D. | 2703 Edmondson Ave | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-19-49 | Holy Redeemer | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 18 1949 | Hunting for Williams, M.D. | George A. Farley | Fulton Ave & Fayette St. |

VS 150

461

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Where exact information is not known, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80015

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80015

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah E. Robinson

2. DATE OF DEATH: Nov. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1006 Madison Ave.

c. Length of stay in Baltimore: 45 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1006 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widow | Oct. 10, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Calvert Co. Md. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Henson | Eliza Hawkins |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Eleanor Holliday | 6243 2 Madison Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 23, 1941, *to* November 15, 1949, *that I last saw the deceased alive on* October 20, 1949, *and that death occurred at* 8:15 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Campbell M. D. | 718 Dolphin St. | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 19, 1949 | Mt. Auburn | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered. Physician: please write the cause of death clearly and legibly. correct age is especially important.

G80016

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80016

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barry Woodburn

2. DATE OF DEATH: Nov. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ped. 11 E H 42
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N. Y.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 7001 Ridge Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 5-21-49 | | 5 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Woodburn
14. MOTHER'S MAIDEN NAME: Beverly Morlan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
DUE TO
(B) surgical creation of auricular septal defect — 24 hrs.
DUE TO
(C) transposition of great arterial vessels

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/8/49
19B. MAJOR FINDINGS OF OPERATION: Transposition of great vessels
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-26-, 1949 *to* 11-9-, 1949 *that I last saw the deceased alive on* 11-9-, 1949 *and that death occurred at* 24 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Richard T. Taylor, Jr. M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 11/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Hospital
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: NOV 19 1949
REGISTRAR'S SIGNATURE: Timothy Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS:

VS 150

Hospital Disposal

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure that the cause of death is correctly and legibly stated. Physicians: please write the cause of death clearly and legibly. Be sure that the cause of death is correctly and legibly stated. Physicians: please write the cause of death clearly and legibly.

G80017

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

759.3 G80017
Registered No.

BIRTH NO. 49-23720

1. NAME OF DECEASED (Type or Print): Baby Boy Yancheski

2. DATE OF DEATH: Nov. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-07
D. STREET ADDRESS (If rural, give location) 315 N. Chapel St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 11-16-49 | | | 30 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: John Yancheski
14. MOTHER'S MAIDEN NAME: Agnes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B) Multiple Cong. anomalies
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/6, 1949 *to* 11/6, 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harvey Dart Squires M. D. | JOHNS HOPKINS HOSPITAL | 11-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Hosp. Disposal | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 10 1949 | Huntington Williams, M.D. | | |

VS 150

Hospital Disposal 159

PLEASE WRITE PLAIN; IF WRITING UNPLAIN, please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and correct age is especially important.

G80018

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

53 Registered No. G80018

1. NAME OF DECEASED (Type or Print): Howard Robert Smith

2. DATE OF DEATH: Nov 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2, Md.
D. STREET ADDRESS (If rural, give location): 1301 St. Paul Street 11-21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Dec 15, 1866 | 82 | 11 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED SALESMAN | WHOL. Butcher | Maryland | USA |

13. FATHER'S NAME: Charles R. Smith

14. MOTHER'S MAIDEN NAME: Caroline Fowble

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Karl J. Steinmueller | Earl Court apts |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno-carcinoma of ascending colon & peritoneal implantations and extension to pleura — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 25, 1949, *to* Nov 18, 1949, *that I last saw the deceased alive on* Nov 18, 1949, *and that death occurred at* 9 15 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Green M. D. | Union Memorial Hospital | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | 11-21-49 | Greenmount Cemetery | Greenmount Ave. & North |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Registrar of Vitals, Md. | John S. Mitchell & Sons | 46E 1900 Eutaw Pl. |

VS 150

PLEASE WRITE PLAINLY, with UNFADING INK. Be sure that the cause of death is correctly and clearly stated. Physicians: please write the cause of death clearly and legibly. Be sure that age is especially important.

G80019

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

19 49-8

Registered No. G80019

1. NAME OF DECEASED (Type or Print): Mrs. Olive Myrtle Dey

2. DATE OF DEATH: November 17, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3018 Woodland Avenue

c. Length of stay in Baltimore: 60 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3018 Woodland Avenue

27-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | May 30, 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Willard Downin

14. MOTHER'S MAIDEN NAME: Sarah Virginia Feigley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ---

17. INFORMANT: Mrs. Ethel J. McFadden ADDRESS: 3018 Woodland Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1-49, 19__, *to* 11-17, 19 49, *that I last saw the deceased alive on* 11-16, 19 49, *and that death occurred at* 9 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: C. D. Thorn M. D.

23B. ADDRESS: 41 E. Chase St

23C. DATE SIGNED: 11/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 19, 1949

24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge

24D. LOCATION (City, town, or county) (State): Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 19 1949

REGISTRAR'S SIGNATURE: Registrar for Baltimore City

25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

55E

PLEASE WRITE PLAINLY. Be sure UNDERLINING is correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80020
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G80020
Registered No.

1. NAME OF DECEASED (Type or Print) **Annie Sacks**

2. DATE OF DEATH **November 18, 49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Sinai Hospital**

c. Length of stay in Baltimore **15 yrs** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **MAryland** B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **2605 Fairview Ave.** 15-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| **Female** | **White** | **Widow** | **1881** | **68** | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **House Wife** | | **Lith** | |

13. FATHER'S NAME **James Cramer**

14. MOTHER'S MAIDEN NAME **Hannah Snyder**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | **Loius Sacks** | **436 Chapel Gate Lane** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral vascular accident, left. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Arteriosclerotic cardiovascular dis

DUE TO

(C) Hypertensive cardiovascular dis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Azotemia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-8-, 1949 *to* 11-18-, 1949, *that I last saw the deceased alive on* 11-18-, 1949, *and that death occurred at* 10:30 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **[signature]** M. D. | **Sinai Hosp.** | **11-18-49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Nov 19, 1949** | **Berkley Va** | **Virginia** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Huntington Williams, M.D. | **Sol Levinson & Bros** | **1126 W North Ave** |

VS 150 (S.E. Harris)

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician: please write the causes of death clearly and legibly. correct age is especially important.

G80021

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80021

1. NAME OF DECEASED (Type or Print): JOHN C. RIPPLE

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 8 N. LAKEWOOD AVE

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 8 N. LAKEWOOD AVE

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | JUNE 10, 1859 | 90 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | City | Maryland | U.S.A. |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| unknown | | Mrs Mary E Boone | 8 N. Lakewood |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Arteriosclerotic C.V. disease

DUE TO

(C) Arteriosclerosis, generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 17, 1949 *to* Nov 18, 1949, *that I last saw the deceased alive on* Nov 18, 1949, *and that death occurred at* 12 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark W. Baker, Jr. M. D. | 2921 E. Federal St. | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-21-49 | Holy Redeemer | BALTIMORE Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Huntington Williams, M.D. | John A. Moran | 3000 E. Balt. St. |

VS 150

92D

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G80022

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80022

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles A. Buck

2. DATE OF DEATH November 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 6842 FAIT Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | MARRIED | September 23, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Store-owner | OWN BUSINESS | MARYLAND | U. S. A. |

13. FATHER'S NAME Charles Buck

14. MOTHER'S MAIDEN NAME Laura Fifer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | NONE | Mrs. Cora L Buck | 6842 FAIT Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Gall Bladder

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| October 26, 1949 | Carcinoma of Gall Bladder with metastases | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October 15, 1949, *to* Nov. 18, 1949 *that I last saw the deceased alive on* Nov. 18, 1949, *and that death occurred at* 9:15 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Spittel Jr. M. D. | Mercy Hospital | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | NOV 21 1949 | LOUDON PARK | FREDERICK RD MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Huntington Williams, M.D. | DIPPEL BROS. | 1800 E LOMBARD ST. |

VS 150

46F

Please write clearly and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80023

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

41°

Registered No. G80023

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William McIntosh

2. DATE OF DEATH Nov. 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 423 N. Grice St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 25 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 423 N. Grice St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md

D. STREET ADDRESS (If rural, give location) 20-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Married | Feb 24-1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Truck Driver | - | Orange Co Va | U.S.A. |

13. FATHER'S NAME Felix McIntosh

14. MOTHER'S MAIDEN NAME Cornelia B Campbell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 214-03-3452

17. INFORMANT Viola Fleety 1512 - 47th NE DC

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Indef.

DUE TO

(B) Arterial Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 17 1949 *to* Nov 18, 1949, *that I last saw the deceased alive on* Nov 16, 1949 *and that death occurred at* 7 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J Edward Fisher M.D. | 1612 E Monument St | 11-18-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov 19 1949 | Mt Calvary Baptist | Orange Co Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Printing for Williams, Md | Robert F Williams | 1525 W Baltimore St |

VS 150

92 B

If cause of death is especially important. Physician: please write the cause of death clearly and legibly.

G80024

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80024

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward Riddle (Edward Wilson Riddle)

2. DATE OF DEATH November 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore 27 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt. Pleasant Beach
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 3-27-22 | 27 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Radio Repairman | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harry L. Riddle | Hattie Frank |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic Pyelonephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Osteomyelitis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-31, 1949, *to* 11-17, 1949, *that I last saw the deceased alive on* 11-17, 1949, *and that death occurred at* 10 15 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Lukens M. D. | JOHNS HOPKINS HOSPITAL | 11-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 21, 1949 | Woodlawn Cemetery | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 19 1949 | Huntington Williams, M.D. | Willis Amoran | 1003 W. Baltimore St. |

VS 150

133a

PLEASE WRITE PLAINLY. Fill all blanks correctly. Items 1 to 17 must be answered. Physicians: please write the cause of death clearly and legibly. Special attention is especially important.

G80025

G80025

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 587

BIRTH NO. Frederick E. Watson Jr.

1. NAME OF DECEASED (Type or Print): Freddie Watson

2. DATE OF DEATH: NOV 19 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Va
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lynnhaven
D. STREET ADDRESS (If rural, give location): Route 1. Box 164

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 12-20-44 | 4 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Fred Watson

14. MOTHER'S MAIDEN NAME: Leona Barnett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (C) Cystic Fibrosis of the Pancreas | 5 mo. 24 wk. |
| DUE TO | (B) Pulmonary Fibrosis and Bronchiectasis Sym. | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (A) Interstitial Pneumonia | 1 week |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9- , 1949 *to* 11-19- , 1949 *that I last saw the deceased alive on* 11-19 , 1949 *and that death occurred at* 6-10 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harold F. Gried M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 11/20/49

24C. NAME OF CEMETERY OR CREMATORY: Forest Lawn

24D. LOCATION (City, town, or county) (State): Norfolk Va.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: North and Pa. Aves

128

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G80026

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1201 G80026

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward C. Taks

2. DATE OF DEATH: Nov 18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 271 Spring Court
C. Length of stay in Baltimore: 7 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 271 Spring Court 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec 13, 1905 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Comfort Spring Co | Machinist | New York City | |

13. FATHER'S NAME: Phillip Taks

14. MOTHER'S MAIDEN NAME: Hannah Beck

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 109-05-9634 | Etta Taks | 271 Spring Court |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 4 days |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 14 *19* 49 *to* Nov 18 *19* 49, *that I last saw the deceased alive on* 11/18 *19* 49 *and that death occurred at* 12 45 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Meyer L. Solomon M. D. | 129 S. Bway | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-20-49 | Mickro- Kodesh Cons. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 20 1949 | Thurlington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80027

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80027 27

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PAUL WAXMAN

2. DATE OF DEATH: November 18, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 713 .. Newington Street 13-07

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 5, 1908
9. AGE (In years last birthday): 41 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Walmans Bakery
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elliott Waxman
14. MOTHER'S MAIDEN NAME: Rbecca ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: Helene Waxman 713 Newington Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23a. SIGNATURE: Carl L. Voyer M.D.
23b. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23c. DATE SIGNED: Nov. 19, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 20/49
24c. NAME OF CEMETERY OR CREMATORY: Bnai Israel Cong.
24d. LOCATION (City, town, or county) (State): County Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949
REGISTRAR'S SIGNATURE: Hunting Town Williams, MD
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1124-26 W North Avenue

VS-191

94a

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Street age is especially important.

G80028 G80028

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 1 2

1. NAME OF DECEASED (Type or Print): LOUIS BERLIN

2. DATE OF DEATH: NOV. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2220 WHITTIER AVE
c. Length of stay in Baltimore: 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 2220 WHITTIER AVE 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | | 71 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10B. KIND OF BUSINESS OR INDUSTRY: GROCER
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: SIMON
14. MOTHER'S MAIDEN NAME: MARY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JENNIE BERLIN ADDRESS: 2220 WHITTIER AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 months
DUE TO
(B) Hypertension & arterio sclerosis — about 15 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb., 1949 *to* Oct. 18, 1949, *that I last saw the deceased alive on* Oct. 18, 1949, *and that death occurred at* 1:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Herman Seidel M. D.
23B. ADDRESS: 2404 E Eutaw Pl
23C. DATE SIGNED: 11/18/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-20-49 | ROSEDALE | BALTO MD. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc. ADDRESS: 2100 Eutaw Place

94a

For data wanted, see correct age is especially important. Physicians: please write the cause of death clearly and legibly.

NOV 20 1949 VS 156

G80029 ✓ G80029

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 470 Registered No.

1. NAME OF DECEASED (Type or Print): BERTHA WICHNER
2. DATE OF DEATH: 11-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2107 Baker St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2107 Baker St

c. Length of stay in Baltimore: 52 Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 66
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert
14. MOTHER'S MAIDEN NAME: Pauline

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Max Wichner ADDRESS: 2107 Baker St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Sclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 - 1948 *to* 11/19 1949, *that I last saw the deceased alive on* 11/19 1949, *and that death occurred at* 6:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edward A. Kaelin M. D.
23B. ADDRESS: 1847 W. Northern
23C. DATE SIGNED: 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-20-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, MD
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

94a

IF CAUSE WHICH GAVE RISE TO CAUSE (A) IS ALSO GIVEN, ENTER IT IN (B). ENTER ONLY ONE CAUSE IN EACH LINE. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80030 ✓ G80030

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54-4 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Ellis Weiner

2. DATE OF DEATH: 11-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University
C. Length of stay in Baltimore: 8 Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 15-13
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4214 Pimlico Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Artist | News Paper | Balto Md | |

13. FATHER'S NAME: Joseph

14. MOTHER'S MAIDEN NAME: Bessie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Bessie Weiner ADDRESS: 4214 Pimlico Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Heart Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1949 *to* 11-19, 1949 *that I last saw the deceased alive on* 11-19, 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph C. Weiner M. D. | 23B. ADDRESS: University Hos | 23C. DATE SIGNED: 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 11-20-49 | 24C. NAME OF CEMETERY OR CREMATORY: Rosedale | 24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949 | REGISTRAR'S SIGNATURE: Huntington Williams M.D. | 25. FUNERAL DIRECTOR: Jack Lewis Inc | ADDRESS: 2100 Eastern Ave

VS 150

FURNARI

157E

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Cause of death should be stated so as to show the primary cause, secondary cause (or complication), and contributory cause (if any), and the order of their etiologic relationship. Certification should be as complete and correct as is especially important.

Med. Exams Case

To be Approved

916.° C80031

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. E 946.

BIRTH NO. B 21082

1. NAME OF DECEASED (Type or Print): Phyliss Isabella Dicke

2. DATE OF DEATH: Nov 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1423 N Gay, St. 8 07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: 8-16-38
9. AGE (In years last birthday): 11
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leonard Dicke
14. MOTHER'S MAIDEN NAME: Phyliss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Second and Third degree
DUE TO
(B) burns, 70% of Body
DUE TO
(C)

ANTZCEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ACCIDENT
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): HOME
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1423 N. GAY ST.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): NOV 15, 1944 10 P m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? HOUSE FIRE 8/7

22. I hereby certify that I attended the deceased from NOV 15, 1949 to NOV 18, 1949 that I last saw the deceased alive on NOV 18, 1949 and that death occurred at 11:10 P m., from the causes and on the date stated above.

23A. SIGNATURE: Wayne L. Mesirll M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 11/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/21/49
24C. NAME OF CEMETERY OR CREMATORY: Balto
24D. LOCATION (City, town, or county) (State): E North Ave

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949
REGISTRAR'S SIGNATURE: Winston Williams, M.D.
25. FUNERAL DIRECTOR: Medard J. Blighs
ADDRESS: 6009 Harford Rd.

VS 150 TO BE APPROVED BY MEDICAL EXAMINER
Carl L. Fox M.D.
180

If any of the above items are unknown, please write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

G80032

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80032
Registered No.

BIRTH NO. 49-15503

1. NAME OF DECEASED (Type or Print): KENNETH R. SMITH — N-1933
2. DATE OF DEATH: November 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6005 Cedonia Avenue
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6005 Cedonia Avenue — 26-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | July 29, 1949 | | 3 | 20 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Raymond K. Smith
14. MOTHER'S MAIDEN NAME: Ruby Anna Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: R K Smith — ADDRESS: same

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Asphyxia due to | |
| | DUE TO aspiration of vomitus | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 6005 Cedonia Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-18-49 ? A m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Aspiration of vomitus — 26/1

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: J. J. McClafferty, M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/21/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: NOV 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mildred T. Blight — ADDRESS: 6009 Harford Rd

VS 151

195D (14)

PLEASE WRITE PLAINLY, in ink. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

CERTIFICATE CORRECTED 12-6-49

C80033 BALTIMORE CITY HEALTH DEPARTMENT 7545 C80033

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Weeks Frank Perry

2. DATE OF DEATH Nov 19-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hosp

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gainesville
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | Nov 15-1915 | 34 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?

10B. KIND OF BUSINESS OR INDUSTRY University of Fla.

11. BIRTHPLACE (State or foreign country) Florida

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Anna Perry - ADDRESS Gainesville Fla.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage - post operative — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) following Cauterization of cervix

DUE TO

(C) repair.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 20 Nov 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov-20-1949 | Gainesville | Florida |

DATE RECEIVED BY LOCAL REGISTRAR NOV 20 1949

REGISTRAR'S SIGNATURE Everington Williams M.D.

25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St Paul St

VS 151

157F ✓

PLEASE WRITE PLAINLY, with unfading ink. Do not use pencil. Do not fold. Make no erasures. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80034 ✓ X G80034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 450. 9 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sister M. Sebastian Dwyer

2. DATE OF DEATH Nov. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Seton Institute

C. Length of stay in Baltimore 6 Yrs. 9 Mos. 20 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buffalo
D. STREET ADDRESS (If rural, give location) 2064 Main Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Jan. , 1862 | 87 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sister of St. Joseph

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) French Creek, New York

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Andrew Dwyer

14. MOTHER'S MAIDEN NAME Elizabeth Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Sr M. Gertrude — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardiac Collapse | 2 days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Gen. arteriosclerosis | ? |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Psychosis due to Cerebr. Arterscl. | 6 yrs + |

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov 16, 1949 *to* Nov 19, 1949, *that I last saw the deceased alive on* Nov 19, 1949, *and that death occurred at* 10:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE John G Brickner M. D.

23B. ADDRESS Seton Institute Balto Md

23C. DATE SIGNED Nov 19 '49

24A. BURIAL, CREMATION OR REMOVAL (Specify) Burial

24B. DATE 11-23-49

24C. NAME OF CEMETERY OR CREMATORY Mt St Joseph

24D. LOCATION (City, town, or county) Buffalo (State) New York

DATE RECEIVED BY LOCAL REGISTRAR NOV 23 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Leonard J Cusk - 5305

ADDRESS Harford Rd.

97

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G80035

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80035

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Matey Hlavac

2. DATE OF DEATH Nov. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 905 N. Belnord Ave

c. Length of stay in Baltimore 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-04
D. STREET ADDRESS (If rural, give location) 905 N. Belnord Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb 12, 1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cabinet Maker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bohemia

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Matey Hlavac

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Anastazie Hlavach ADDRESS 905 N. Belnord Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 2.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION Sept 16, 1949

19B. MAJOR FINDINGS OF OPERATION Inoperable Carcinoma of Stomach

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 5, 1949, *to* Nov 18, 1949 *that I last saw the deceased alive on* Nov. 16, 1949, *and that death occurred at* 11 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Joseph Pokorny M. D.

23B. ADDRESS 2200 E Madison St

23C. DATE SIGNED 11/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11-21-49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 20 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Frank Groschon ADDRESS 900 E Chester St

VS 150

46B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80036 — Andersubrew — G80036

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Emilie Andersubrew
2. DATE OF DEATH: Nov 18, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Lincoln Home
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hampstead & 21st Ave
c. Length of stay in Baltimore: 58 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto, Md 21-07
D. STREET ADDRESS (If rural, give location): 6507 Old Harf. Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W. | Widowed | Nov 26. 1873 | 75 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Germany. | |

13. FATHER'S NAME: John Muller
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Dora Wagner — ADDRESS: 2008 Westfield Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: years.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 1, 1949 *to* 11/18, 1949, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hans. Godfrey M. D. | 5703 Harford Rd | 11/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 21, 49. | Moreland | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 20 1949 | Registrar Williams, M.D. | L. Heemann & Son | 6067 Harford Rd. |

VS-150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80037 BALTIMORE CITY HEALTH DEPARTMENT 89-1 G80037

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print) PEGGY JUSTICE or Evelyn Justice

2. DATE OF DEATH November 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 228 S. Anne Street 7-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year, months, days. If under 24 hours, hours, min.) |
|---|---|---|---|---|
| female | white | Widowed | Not known | 28 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Not know
14. MOTHER'S MAIDEN NAME Not know
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Leo Bonski 1830 E. Preat St

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fatty degeneration of liver | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Kreyd M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Nov. 17, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Nov-21-49
24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary
24D. LOCATION (City, town, or county) (State) German Hill Road

DATE RECEIVED BY LOCAL REGISTRAR NOV 20 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR J. D. Gretlinger & Sons ADDRESS 190 S. Paca St

VS 151

correct age is especially important. Physicians: please write the name of death county and city.

124 C

G80038 X ✓ 46 G80038

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): George W. Everts

2. DATE OF DEATH: NOV 19 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland [redacted]

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Texas
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): League City
D. STREET ADDRESS (If rural, give location): Box 301

5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: 6-30-49 | 9. AGE (In years last birthday): If Under 1 Year: Months 5, Days 16 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Texas | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Everts

14. MOTHER'S MAIDEN NAME: Margaret Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: [redacted] ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

DUE TO

(B) Transposition of the Great Vessels — Congenital

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/19/49

19B. MAJOR FINDINGS OF OPERATION: Transposition of the Great Vessels

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-11-49 *to* 11-19-49, *that I last saw the deceased alive on* 11-19-1949, *and that death occurred at* 9:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: [redacted]

23C. DATE SIGNED: 11/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 11-23-1949

24C. NAME OF CEMETERY OR CREMATORY: FOREST PARK

24D. LOCATION (City, town, or county) (State): HOUSTON TEXAS

DATE RECEIVED BY LOCAL REGISTRAR: NOV 26 1949

REGISTRAR'S SIGNATURE: [signature] Williams, M.D.

25. FUNERAL DIRECTOR: H.W. JENKINS & SONS CO. ADDRESS: 4905 YORK RD

157E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80039

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. G80039

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Henry Seets

2. DATE OF DEATH: Nov. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Colonial Nursing Home

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2006 Hollins St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 12, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Policeman | Balto. City | Maryland | U. S. A. |

13. FATHER'S NAME: George Henry Seets

14. MOTHER'S MAIDEN NAME: Anna Hoffman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | 216-22-4688 | J. Melvin Seets | 2130 Hollins St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Oedema

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular

DUE TO

(C) Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 15, 1949 *to* Nov 18, 1949 *that I last saw the deceased alive on* Nov 18, 1949, *and that death occurred at* 11:00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|---|
| Robert C. Ritsch | | 2151 Walbrook Ave | 11/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Geo. L. Schwab | 2101 Frederick Ave. |

VS 150

925

Street age is especially important. Physicians: please write the cause of death clearly and legibly.

G80040

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G80040

1. NAME OF DECEASED (Type or Print) Ida MAY BARTON | 2. DATE OF DEATH Nov. 20/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2500 ST. PAUL ST.

C. Length of stay in Baltimore 5 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2500 ST. PAUL ST. 12 26

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 4/24/1872 | 77 | 3 | 27 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | Housework | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joshua Boston Harford County | Margaret Jones Harford County |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | None | Mrs. Boston | 2500 St. Paul |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Arteriosclerotic Cardiovascular disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 14 1949, *to* Nov. 20, 1949 *that I last saw the deceased alive on* Nov. 20, 1949, *and that death occurred at* 4:55 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry B. Atkey M. D. | 2504 St. Paul St. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 23 1949 | Forest Lawn | Forest Lawn Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | W. Frank Hobbs | Forest Lawn Rd |

VS 150

935

To be approved by Medical Examiner

E 903.5 G80041

BIRTH NO. G80041

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Colgan, Ida Rebecca — N-8210

2. DATE OF DEATH: 11-17-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1105 S. Paca Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W. | Married | July 21, 1890 | 59 | 3 | 27 | 20 | 40 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Virginia | U.S.A. |

13. FATHER'S NAME: William Buck.

14. MOTHER'S MAIDEN NAME: Sarah E. Wilcox

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William Colgan, | 1105 S. Paca St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pulmonary Embolism | |
| DUE TO (B) | Fracture of Skull and Hemorrhage | |
| DUE TO (C) | Injury | |

CERTIFICATION APPROVED BY: Wm. H. Hemmings, M.D. Per. Earl L. Boyle M.D. CHIEF OR ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/4/49 | Autopsy performed from Coroner | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Street | Bell Rock Court |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11 1 49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Fell & Cut |

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, *to* Nov 17, 1949, *that I last saw the deceased alive on* Nov 17, 1949 *and that death occurred at* 3:40 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 17 [illegible] | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11/21/49 | U.S. National | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

186a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80042

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80042

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE ALBAUGH

2. DATE OF DEATH: 11/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1630 LIGHT ST. #302-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | | 10/2/1884 | 65 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MARYLAND | |

13. FATHER'S NAME: GRAFTON THOMAS ALBAUGH

14. MOTHER'S MAIDEN NAME: EMMA JANE MARSH

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | ANNA ALBAUGH. | 1630 LIGHT ST BALT. #30 MD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | LOCULATED PNEUMOTHORAX | 48 hrs. |
| DUE TO (B) | BRONCHO PLEURAL FISTULAR | 48 hrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | EMPHYSEMATOUS BLEBS LEFT LOWER LOBE | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | O/D HEALED TBC LEFT UPPER LOBE | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/16/49 | SCARED TBC LEFT UPPER LOBE EMPHYSEMATOUS BLEBS LEFT LOWER LOBE | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/3, 1949, *to* 11/18, 1949, *that I last saw the deceased alive on* 11/18, 1949, *and that death occurred at* 6:00 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. E. Mart M. D. | Mary Land General Hosp | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 11/22/49 | Mt. Carmel | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Wm Cook Inc | 1217 St. Paul St. |

VS 150

136

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G80043

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80043

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Fenton Swann

2. DATE OF DEATH 11/17/49 10:30 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1405 W. Ostend St

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1405 W. Ostend St. 21-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 4/15/1867 | 82 | 7 | 2 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer

10B. KIND OF BUSINESS OR INDUSTRY Oil Refining Co

11. BIRTHPLACE (State or foreign country) York Pa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Swann

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Elmer Swann ADDRESS 108 Jackson Square

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 11-11-49 (6 days) ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-13 19 49 *to* 11-17 19 49 *that I last saw the deceased alive on* 11-17 19 49 *and that death occurred at* 10:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Edwin P. Ulrich Jr. M. D.

23B. ADDRESS 1227 Wash Blvd

23C. DATE SIGNED 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11/21/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

94a

G80044

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
191 Registered No. G80044

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Coleman — 516617
2. DATE OF DEATH: 11-20-49
3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparrows Point
D. STREET ADDRESS (If rural, give location): 911 "J" St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | W | 6-22-84 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Bethlehem Steel | Va. | |

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT — ADDRESS |
|---|---|---|
| — | — | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — (Interval between onset and death): 3 wks

DUE TO

(B) Ureteral obstruction — ? 3 wks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Carcinoma of anus — 8 mos.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-21-49 | Carcinoma of anus (squamous) with invasion of ureters | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 10-7 1949 *to* 11-.. 1949, *that I last saw the deceased alive on* 11-18 1949, *and that death occurred at* 12 35 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul C. Adkins, M.D. M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-23-49 | Coleman Farm | Prince Geo. Co. - Va. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Samuel W. Sullivan Jr. — 1011 N. Arlington Ave 46D

VS-150

PAUL C. ADKINS

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80045

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80045

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael Gundersheimer

2. DATE OF DEATH: Nov. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Georgia Apts.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2520 Linden Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 2520 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | August 10, 1892 | 57 | 3 | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | Merchandise | Baltimore, Md. | |

13. FATHER'S NAME: Philip W. Gundersheimer

14. MOTHER'S MAIDEN NAME: Bergman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Esther Gundersheimer | 2520 Linden Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute coronary thrombosis | 1 hr |
| DUE TO | Coronary arteriosclerosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Recurrent coronary thrombosis | 3 yrs |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1946 19__, *to* 11-20 1949 *that I last saw the deceased alive on* 11/20 19 49, *and that death occurred at* 2:57 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton B. Kaufman | 2320 Eutaw Pl. | 11/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 21, 1949 | Baltimore Hebrew | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | David Sondheim | 1902 Eutaw Pl. |

David Sondheim Son

94a

VS 150

Correct age is especially important. Physician: please write the

G80046

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80046

1. NAME OF DECEASED (Type or Print): IRENE ROSS

2. DATE OF DEATH: Nov. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1223 McCulloh St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1223 McCulloh St. 11-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | Jan 1, 1901 | 48 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Alexander Robinson

14. MOTHER'S MAIDEN NAME: Irene Bess.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Lillie Robinson ADDRESS: 539 Wilson St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension + hypoplasia - DUE TO Hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis + DUE TO Nephritis. — INTERVAL BETWEEN ONSET AND DEATH: 2

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-14 1949 *to* 11-18 1949, *that I last saw the deceased alive on* 11-18 1949, *and that death occurred at* 4 3/4 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thurston E. Hanson M. D. | 224 Medford Ave | 11-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-22-49 | Mt. Calvery Cem. | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Mrs. Frances A. Hensley 573 W. Biddle St. |

VS 150

131a

correct age is especially important. Physicians: please write the cause of death plainly.

IS-115659

G80047

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

073 G80047 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Grooms

2. DATE OF DEATH: 11-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 704 Bruce Street 16-03

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: ?
9. AGE (In years last birthday): 47?
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Thomas Chinn
14. MOTHER'S MAIDEN NAME: Harriett Presco

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Syphilitic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1-12-48
19B. MAJOR FINDINGS OF OPERATION: Ulcer, Right Leg
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-4, 1947, *to* 11-18, 1949, *that I last saw the deceased alive on* 11-18 1949, *and that death occurred at* 2:15 PM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 11-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/21/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): West Port. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Lucretia Williams, M.D.
25. FUNERAL DIRECTOR: Metropolitan Funeral Home Inc. ADDRESS: 933 Monument St

VS 150

30E

Physicians: please write the cause of death and the correct age is especially important.

G80018

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80018

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEOLA GERTRUDE HARRIS

2. DATE OF DEATH: Nov. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 513 N. Longwood St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | 8/27/80 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Ohio | USA |

13. FATHER'S NAME: George Harmon

14. MOTHER'S MAIDEN NAME: Olegrath ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | -- | | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of breast, right, metastatic to all regional lymph nodes — 1 year

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | none | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| --- | --- | --- |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| --- m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | --- |

22. *I hereby certify that I attended the deceased from* Oct. 27, 1949, *to* Nov. 17, 1949, *that I last saw the deceased alive on* Nov. 17, 1949 *and that death occurred at* 5:05P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Raymond E. Brown Day M. D. Raymond E. Brown, S.A. Surg: Officer of | US Marine Hospital, Balto, Md. | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 21/49 | Mt. Olivet Cemetery | 2930 Frederick Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Harry H. Wirtzfe. | 4101 Edmondson Ave |

VS 150

50

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80049

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450 ✓

Registered No. G80049

1. NAME OF DECEASED (Type or Print): Mary A. Fitch

2. DATE OF DEATH: Nov. 18, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland ✓

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1048 W. Barre St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 1048 W. Barre St. 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F M | White | Widowed | 12/17/1864 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | NOne | Washington DC. | USA |

13. FATHER'S NAME: John Roth

14. MOTHER'S MAIDEN NAME: Mary Simon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | NO | Albert L.Fitch | 1048 W. Barre St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | pyelo nephritis | 1 year |
| DUE TO (B) | generalized arteriosclerosis | ? |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 12/29, 1948 *to* 11/18, 1949 *that I last saw the deceased alive on* 11/18, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Grace A Kemp M. D. | 3030 Edmondson Ave | 11/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 21, 1949 | Oaklawn Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | J.T.Stansbury | 2700 Edmondson Ave. |

VS 150

133a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80050 49-18285 BALTIMORE CITY HEALTH DEPARTMENT G80050

# CERTIFICATE OF DEATH

751 Registered No.

BIRTH NO. 49-18285

1. NAME OF DECEASED (Type or Print) BABY IRENE MOONEY

2. DATE OF DEATH Nov. 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) BON SECOURS HOSPITAL

c. Length of stay in Baltimore Yrs. Mos. Days 80

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD. B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D STREET ADDRESS (If rural, give location) 4121 WHITE AVE 27-34

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | SINGLE | 8/30/49 | | 2 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CHILD. | | BALTIMORE, MD. | |

13. FATHER'S NAME MR. ERNEST MOONEY

14. MOTHER'S MAIDEN NAME ROSE LILLIAN JACOB

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | NONE | ERNEST MOONEY | 4121 WAITE AVE. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital spina bifida — INTERVAL BETWEEN ONSET AND DEATH: 80 days
DUE TO
(B) Chronic debilitation + cachexia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug. 31, 1949 *to* Nov. 19, 1949 *that I last saw the deceased alive on* Nov. 17, 1949, *and that death occurred at* 9:00 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Paul B. Manning M. D. | Bon Secours Hosp. | 11/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| BURIAL | NOV 21 1949 | BALTIMORE CEMETERY | NORTH AVE & CAY ST | MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams M.D. | Duffel Bros | 1800 E LOMBARD ST. |

VS 150

157B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80051 X ✓ G80051

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 420.1 Registered No.

1. NAME OF DECEASED (Type or Print): McKibbon, Joseph Henry

2. DATE OF DEATH: Nov 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. Marine Hospital
c. Length of stay in Baltimore: 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.J.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pennsville RFD
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb 4, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | Seaman | Ky. | USA |

13. FATHER'S NAME: James McKibbon

14. MOTHER'S MAIDEN NAME: Sufronia Miller

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | unk | Records | USMH Balto., Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial infarction | 7 days |
| DUE TO (B) | coronary arteriosclerosis | unk |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* Nov 14, 19 49, *to* Nov 20, 19 49, *that I last saw the deceased alive on* Nov 20, 19 49 *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. L. Lewis M.D. M. D. | O.O.D. USMH Balto., Md. | Nov 20, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Evergreen | [illegible], N. J. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Howard D. Steward | 2503 Edmondson Ave. |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

680052

X ✓

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

680052 Registered No.

1. NAME OF DECEASED (Type or Print) Leonard, Mr Frank

2. DATE OF DEATH November 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hospital

c. Length of stay in Baltimore 30 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 200 St Helena Ave Dundalk

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH September 10, 1890

9. AGE (In years last birthday) 59 yrs (If under 1 year: Months: Days; If under 24 hours: Hours: Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) England

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leonard Henry

14. MOTHER'S MAIDEN NAME Huckster

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT Mrs Emily Leonard ADDRESS 200 St. Helena Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Status Asthmaticus — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Bronchial Asthma — 20 yrs.

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C) Hypertensive Cardiovascular Disease — 20 yrs

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 16, 1949 to November 19, 1949, that I last saw the deceased alive on [illegible], 19 49 and that death occurred at 12.40 P m., from the causes and on the date stated above.

23A. SIGNATURE Ronald T. Heaton M. D.

23B. ADDRESS Church Home + Hosp.

23C. DATE SIGNED November 19, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Nov 21 1949

24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery

24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 21 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR ADDRESS Roland L. Fisher, 2112 Dundalk Ave.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

G80053 — G80053

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-25015 — Registered No. 776

1. NAME OF DECEASED (Type or Print): BABY BOY BRADLEY
2. DATE OF DEATH: 11-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
c. Length of stay in Baltimore: 8 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD. B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 607 W. 38TH ST. 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | SINGLE | 11-12-49 | | | 8 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| INFANT | | — | |

13. FATHER'S NAME: JAMES BRADLEY
14. MOTHER'S MAIDEN NAME: MARIE LOUISE McGUIRE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | | — | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-12, 1949, *to* 11-20, 1949 *that I last saw the deceased alive on* 11-20, 1949, *and that death occurred at* 1:20 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James A. Roberts M. D. | Mercy Hospital | 11-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-21-49 | NEW CATHEDRAL | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | [illegible] for Wilmer Williams M.D. | H.W. JENKINS & SONS CO. | 4909 YORK RD. |

VS 150

159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80054

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80054

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edith M. Ridley

2. DATE OF DEATH Nov. 19 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md. B. COUNTY Caeto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riderwood.
D. STREET ADDRESS (If rural, give location) Sherwood Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Aug 23 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | New York City | U.S.A. |

13. FATHER'S NAME Henry Russell Downe

14. MOTHER'S MAIDEN NAME Edith Mitchell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | (INTERVAL BETWEEN ONSET AND DEATH) |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | Hemorrhage from Esophageal Varices | 42 hrs. |
| DUE TO (B) | Cirrhosis of Liver | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis, generalized. Arteriosclerotic Heart Disease | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Nov. 18 1949 *to* Nov. 19, 1949, *that I last saw the deceased alive on* Nov. 19 1949 *and that death occurred at* 2 30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Lawrence Jr. M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 1949 | Loudon Park | Caeto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 21 1949 | [illegible] Washington Boulevard, Md. | Henry W. Jenkins & Sons Co 4905 York Rd |

VS 150

124B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80055

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80055

Registered No.

1. NAME OF DECEASED (Type or Print): James S Murray

2. DATE OF DEATH: Nov. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4411 Greenway
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 77-11
D. STREET ADDRESS (If rural, give location): 4411 Greenway Guilford

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | W. | married | Feb 3 1869 | 80 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| V. Pres. | B+O R.R. | Balto. Md | U.S.A. |

13. FATHER'S NAME: John Rollen Murray

14. MOTHER'S MAIDEN NAME: Mary Ann Griffin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | | Dr. Jas. S. Murray Jr. | 4411 Greenway |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Broncho Pneumonia (Terminal) | 2 days |
| DUE TO | Hypostatic Congestion | 1 year |
| (B) | | 2 years |
| DUE TO | Arteriosclerosis | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Jan 1st, 1944, *to* Nov. 14th, 1949, *that I last saw the deceased alive on* Nov 19th, 1949, *and that death occurred at* 1130 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1309 N. Calvert St | Nov 21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 22/49 | Loudon | Bel Air Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | [signature] | Henry W. Perkins Sons & Co | 49 & York Rd. |

VS 150

937 Mu 8725

Correct age is especially important. Physician: please write plainly and fill in all items.

G80056

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80056

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY E. WONNEMAN

2. DATE OF DEATH: November 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 701 Glenwood Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | | Aug. 20, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ENGINEER | RAILROAD | BALTO., MD. | U.S. |

13. FATHER'S NAME: HENRY WONNEMAN

14. MOTHER'S MAIDEN NAME: ROSE DUNBAR

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 711-07-8772 | J.W. COX | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial insufficiency | months |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Coronary sclerosis | years |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Angina pectoris | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R S Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: NOV. 21, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-23-1949 | [redacted] | BALTO MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams M.D. | [redacted] | YORK RD. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a Elmer W. Coplin 924 E. Eager St

CERTIFICATE CORRECTED 3-8-50

G80057 — BALTIMORE CITY HEALTH DEPARTMENT — G80057

BIRTH NO.

# CERTIFICATE OF DEATH

175 Registered No.

1. NAME OF DECEASED (Type or Print): Hattie Goldberg

2. DATE OF DEATH: November 19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore; D. STREET ADDRESS (If rural, give location) 2808 Suffolk Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2808 Suffolk Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years. Last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 1907 | 42 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10B. KIND OF BUSINESS OR INDUSTRY: B&O R.R. B.& E.R.R

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis N. Goldberg

14. MOTHER'S MAIDEN NAME: Sarah Rabinowitz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Rubin Goldberg - 2808 Suffolk Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Ovary. — INTERVAL BETWEEN ONSET AND DEATH: 8 months

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 1, 1949, *to* Nov. 19, 1949, *that I last saw the deceased alive on* Nov 19, 1949, *and that death occurred at* 5:45 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel V. Taylor, M. D. | 3600 Park Heights Ave | Nov. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-49 | Aitz-Chaim Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 VS 150 | Huntington Williams, M.D. | Sol. Levinson & Bros. | 1124-26 N. North Ave. |

49a

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G80058

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80058

1. NAME OF DECEASED (Type or Print): Sarah Goldberg

2. DATE OF DEATH: 11/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 65 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Maryland
D. STREET ADDRESS (If rural, give location): 2808 Suffolk Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Srabin Rabinowitz

14. MOTHER'S MAIDEN NAME: Annie Schreiber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rubin Goldberg ADDRESS: 2808 Suffolk Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia & Gastro Intestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis & Hypertensive Cardio-Vascular Renal Disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/19, 1949 *to* 11/20, 1949, *that I last saw the deceased alive on* 11/20, 1949, *and that death occurred at* 5:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leon E. Kanel M. D.

23B. ADDRESS: Sinai Hospital

23C. DATE SIGNED: 11/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-21-49

24C. NAME OF CEMETERY OR CREMATORY: Atz Chaim Corp.

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR: Sol. Levinson & Bro. ADDRESS: 1124-26 W. North Ave.

VS 150

121a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80059 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Reg. No. 1 — G80059 — Registered No.

1. NAME OF DECEASED (Type or Print): Sarah Ribakow

2. DATE OF DEATH: Nov 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2811 Norfolk Ave
c. Length of stay in Baltimore: 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2811 Norfolk Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Max Rombro

14. MOTHER'S MAIDEN NAME: Toba Abramovitz

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William A Ribakow | 2811 Norfolk Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 2 weeks |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 9, 1949 *to* Nov 19, 1949, *that I last saw the deceased alive on* Nov 18, 1949, *and that death occurred at* 7.10 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melton B. Kress M. D. | Medart Bldg | 11/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 21, 1949 | Hebrew Rosedale Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death plainly,

G80060

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

150-1

G80060

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Georgiana Nelson

2. DATE OF DEATH: Nov. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley Street

5. SEX: Fe.
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 3 1881
9. AGE (In years last birthday): 68
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Howard County
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Aaron Cook
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): None
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Isaac Green ADDRESS: 10 Shipley Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic gangrene - feet

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Hypostatic pneumonia

DUE TO (C) Generalized arteriosclerosis

Malnutrition

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/12/ , 1949 *to* 11/20/ , 1949 *that I last saw the deceased alive on* 11/20/ , 1949 *and that death occurred at* 1:50 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: C. C. Green M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 11/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 23, 1949
24C. NAME OF CEMETERY OR CREMATORY: Fiester Star
24D. LOCATION (City, town, or county) (State): Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Christian Williams, M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave

VS 150

97

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80061

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31

G80061

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Grace Shipley

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2113 McCulloh St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2113 McCulloh St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | Jan. 5, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Joseph Shipley

14. MOTHER'S MAIDEN NAME: Ida Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Helen Shipley ADDRESS 2113 McCulloh St.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 1 wk. |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized arteriosclerosis | ? |
| DUE TO | | |
| | (C) Essential Hypertension | ? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 7-11, 1949 *to* 11-17, 1949, *that I last saw the deceased alive on* 11-17, 1949, *and that death occurred at* 11 1/2 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clifford R. Musser M. D. | 2309 Druid Hill | 11-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 21, 1949 | Mt. Auburn | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Winston Williams M.D. | Holland Funeral Home | 1681 Druid Hill Ave. |

VS 150

83a

correct age is especially important. Physician: please write the name

G80062

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G80062

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Mary Blackman

2. DATE OF DEATH: Nov. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1515 W. Mosher St.

C. Length of stay in Baltimore: 23 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-or
D. STREET ADDRESS (If rural, give location): 1515 W. Mosher Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | W | Nov. 13, 1904 | 45 | 0 | 4 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lancaster S.C.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John Foster
14. MOTHER'S MAIDEN NAME: Easter Stradford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Louise ADDRESS: 1217 Hollins Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

DUE TO

(B) Arterio-sclerosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 3, 1949 *to* Nov. 17, 1949, *that I last saw the deceased alive on* Nov 17, 1949, *and that death occurred at* 10:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Reynold Hoffman Nelson M. D.
23B. ADDRESS: 501 Cherry Hill Road
23C. DATE SIGNED: 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 11/21/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn
24D. LOCATION (City, town or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Chas L Harper ADDRESS: 5[illegible] Carrollton Ave

VS 150

83a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80063 G80063

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERTHA BRODSKY
2. DATE OF DEATH: 11-21-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewndall
C. Length of stay in Baltimore: 40 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 28 N Chester St 6.04
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH
9. AGE (In years last birthday): 60 If under 1 Year: Months Days If under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Simon
14. MOTHER'S MAIDEN NAME: Fannie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Jacob Janofsky ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic cardio vascular dis. — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) arteriosclerosis — years
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes mellitus, T.B. pulm. — years

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-19 19 49 *to* 11-21 19 49 *that I last saw the deceased alive on* 11-21 19 49 *and that death occurred at* 2:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE Henry Nagel M. D.
23B. ADDRESS Lewndale Home
23C. DATE SIGNED 11-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-22-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Transcribing for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 7100 Eastern Ave

VS 150

12B

correct age is especially important. Physicians, please write the cause of death

G80067

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G80067

1. NAME OF DECEASED (Type or Print): Louis Abelson

2. DATE OF DEATH: Nov. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: 47 Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-07
D. STREET ADDRESS (If rural, give location): 423 West Barre St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | | 53 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | | Lith | |

13. FATHER'S NAME: Albert

14. MOTHER'S MAIDEN NAME: Anna

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Sophie Abelson | 420 W Barre St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D. | | Nov. 20, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-49 | United Hebrew | Bath Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eastern Ave |

VS 151

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80065

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59

Registered No. G80065

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JACOB KALICHMAN

2. DATE OF DEATH: 11-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1701 Ellamont St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fenhlatt Howe

c. Length of stay in Baltimore: 37 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2631 Park Heights Terrace

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired TAILOR | SELF | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank | Not Known |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | William Kalichman |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Circulatory Collapse — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Nephritis & Uremia — 3 months

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 10 '49 *to* Nov. 21, 19 49, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:27 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. Harry Ashman M. D. | 1921 W North Ave | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-49 | Hebrew Mt Carmel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Jack Levis Inc | 2100 Eutaw Pl |

1318

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr Grazians

C80060 Hanford

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Hanford

Registered No. C80068

1. NAME OF DECEASED (Type or Print): Mary A. Davidson

2. DATE OF DEATH: Nov 18-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2748 Scoley Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06

C. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2748 Scoley Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 10-13-1883 | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | New York | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs John A Davidson | 2748 Scoley Ave |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. INTERVAL BETWEEN ONSET AND DEATH

I **DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio sclerosis, gangrene of left foot, myocardites, diabetes — DUE TO — ? (interval)

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B) Senility — DUE TO

(C)

II **OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY |
|---|---|---|
| Aug 1949 | Arterial gangrene left lower leg (amputation mid thigh) | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 1949 *to* Nov 18, 1949, *that I last saw the deceased alive on* Nov 17, 1949, *and that death occurred at* 4:00 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Theodore L. Grazians, M. D. | 2802 Harford Rd 18 | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-22-49 | Mordant Pk | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Leonard Fleck | 535 Hanford |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80067

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Hyo. 1

G80067

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH THOMAS LANDERS

2. DATE OF DEATH: 11-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital (DOA)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1017 DARLEY AVE 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | MARRIED | 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LIEUT. | BALTO POLICE DEPT. | BALTIMORE, MD | |

13. FATHER'S NAME: BERNARD JOS LANDERS

14. MOTHER'S MAIDEN NAME: W. SCHRIVER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | NONE:- | MRS. MARY L. LANDERS | 1017 DARLEY AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer M.D. | | NOV. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-21-49 | HOLY REDEEMER | CITY |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND 94a |

VS 151

NOTICE: Physicians: please write the causes of death clearly and legibly. Accuracy in filling out this certificate is especially important.

G80068 — BALTIMORE CITY HEALTH DEPARTMENT — G80068

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude M. Kouk

2. DATE OF DEATH: Nov. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1812 Warwick Ave. 15-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widow | May 5, 1886 | 63 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Baltimore, Md. | |

13. FATHER'S NAME: Jesse Heiser

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. John W. Robinson — ADDRESS: 3315 Elmley Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: Emil Bayer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 20 Nov 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Woodlawn Cem. | Woodlawn, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949

REGISTRAR'S SIGNATURE: Lucretia Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80069

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903.0

Registered No. G80069

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LILLIE G. PURDY — N-8110

2. DATE OF DEATH: NOV. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2946 Presstman St. 16 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Sept. 4, | about 80 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | own home | Ellicott City, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Allen T. Fort | Cordelia Clark |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Miss Estelle R. Purdy | 2946 Presstman St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 11 DAYS

DUE TO

(B) Cerebral Arteriosclerosis — 15 YRS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

CERTIFICATION APPROVED BY
R S Fisher
for C. J. Lubinski, M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Fracture, ctf. femur — 32 days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov 3/49 | Fracture, ctf femur | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | 2946 Presstman St. |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 14, 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Slipped and fell to the floor |

22. *I hereby certify that I attended the deceased from* Nov 1 1949 *to* Nov. 19, 1949, *that I last saw the deceased alive on* Nov 19, 1949, *and that death occurred at* 5:15 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David Aved M. D. | Univ. Hosp. Balto-1 | Nov. 19 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/22/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

186a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80070

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80070

1. NAME OF DECEASED (Type or Print): Robert Washington

2. DATE OF DEATH: Nov 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1346 Whatcoat st
C. Length of stay in Baltimore: 30 years. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1346 Whatcoat st 15-01

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | l. c | married | June 12, 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plaster | | Va | |

13. FATHER'S NAME: Beverly Washington

14. MOTHER'S MAIDEN NAME: matilda ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Anna Posey 1346 Whatcoat st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Myocarditis | Unknown |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Unknown | |
| DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-24, 1949 *to* 11-18, 1949, *that I last saw the deceased alive on* 11-17, 1949, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank A Saunders M. D. | 1029 N. Stricker St | 11-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-49 | Mt Auburn. | md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | George B. Nelson 1303 Druidsman st |

VS 150

93E

correct age is especially important. Physicians: please write the cause of death very plainly.

G80071

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80071 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Lillian Canby

2. DATE OF DEATH: Nov. 18. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1328 Kenwood Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE: Maryland
COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-09
D. STREET ADDRESS (If rural, give location): 1305 Homewood Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: May 19. 1885
9. AGE (In years last birthday): 64 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?: U. S

13. FATHER'S NAME: James Manning
14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS: Mrs. Kiefner 1328 N. Kenwood Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: appx 3-4 yrs

DUE TO

(C) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 23 Feby 19 49, *to* 18 Nov 19 49, *that I last saw the deceased alive on* 18 Nov 19 49, *and that death occurred at* 2.30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 1518 N. Milton Ave
23C. DATE SIGNED: 20 Nov. 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 22/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: (Ryda) Wiedefeld Goo & Biddist
ADDRESS

Dr. Goodwin 1512 Milton Ave 1310

correct age is especially important. Physicians: please write the cause of death plainly.

BIRTH NO. G80072 W-94420

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80072 E903.0 N-855.0

1. NAME OF DECEASED (Type or Print): JOYCE A. (BAIN) VAIN
2. DATE OF DEATH: November 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1727 Lamont Avenue 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Nov. 16, 1947 | 2 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Vain
14. MOTHER'S MAIDEN NAME: Lillian C. Eder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Andrew Vain ADDRESS: 1727 Lamont Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage (subdural and subarachnoid)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Malnutrition

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1727 Lamont Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): November 20, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Stumbled and fell to the floor

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-21-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/21/49 | Holy Redeemer | Balto, |

DATE RECEIVED BY REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Kenneth for Williams, M.D.
25. FUNERAL DIRECTOR: Philip Henry Sons ADDRESS: 2024 Orleans St

186a

VS 151

Please write plainly. Physicians: please write the causes of death clearly and legibly. Answer all questions. Be sure that the information given is correct and complete. Do not abbreviate. Use ink. Do not use pencil. Be sure that the age is especially important.

Orig G80073 48-20576 ✓ 580 G80073

BIRTH NO. Graftcale

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Bernadine Smith
2. DATE OF DEATH: Nov. 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY 7-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): J H Hosp.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 1 Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 1018 N. Washington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | 9-28-48 | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| home | — | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ben Smith | Lillian Banks |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hepatic insufficiency
DUE TO
(B) Hepatitis
DUE TO
(C) Septicemia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
chronic anemia

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ✓ NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-26-, 1949, *to* 11-19-, 1949, *that I last saw the deceased alive on* 11-19-, 1949, *and that death occurred at* 8 20 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leona Z Smith M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov 22 1949 | Mt Calvary Cemetery | A. A. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Robert F Williams 15-15 McElderry St |

VS 150

1250

G80074 BALTIMORE CITY HEALTH DEPARTMENT G80074

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Cora Elizabeth Jones.

2. DATE OF DEATH: 11-18-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2608 Puget St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 2608 Puget St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 2608 Puget St.

5. SEX: Female
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 6-12-1881
9. AGE (In years last birthday): 68 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Johnson.
14. MOTHER'S MAIDEN NAME: Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles Procter. ADDRESS: 2608 Puget St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.): Chronic Myocarditis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5/1/49

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/29/ 1949 *to* 11/18/ 1949, *that I last saw the deceased alive on* 11/17/ 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. B. Hartmann, M. D.
23B. ADDRESS: 450 W. Biddle St
23C. DATE SIGNED: 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-21-1949
24C. NAME OF CEMETERY OR CREMATORY: W. Lawn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Ketter R Williams
ADDRESS: 3224 Edmondson Ave

937

correct age is especially important. Physicians, please write

6

G80075 G80075

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth Brewer
2. DATE OF DEATH: 11-17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2801 Remmington Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2801 Remmington Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-06
D. STREET ADDRESS (If rural, give location) 2801 Remmington Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | Widow | Jan. 1, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Millsboro, Md. | U.S.A. |

13. FATHER'S NAME: Henry Thomas
14. MOTHER'S MAIDEN NAME: Ella Jackson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Samuel A. Stewart. | 1827 Hanover St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hypertension & Cirrhosis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7/10/49 *to* 11/16/49, *that I last saw the deceased alive on* 11/12/49, *and that death occurred at* 3 00 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Garner M.D. | 25-3 Cresent St | 11/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-21-1949 | Mt. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 322 N Schroeder St |

VS 1550

93c

G80076 CERTIFICATE CORRECTED 11-23-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80076

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KOMMALAN — KLOMMALAN — AUGUST

2. DATE OF DEATH: 11-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — University Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2135 Homewood Ave 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | Married | Dec 27-1922 | 26. | 11 | 9 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Field Engineer | | Balto. Md | |

13. FATHER'S NAME: George W. Kommalan

14. MOTHER'S MAIDEN NAME: Marie H. E. Kommalan

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | | 210-14-4281 | Kommalan Mrs. Geo. Kommalan | 21 Lancaster Road |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Brain abscess, left Parital Lobe | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-17-49 | Brain abscess | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-17, 1949, *to* 11-19, 1949, *that I last saw the deceased alive on* 11-19, 1949, *and that death occurred at* 9:15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Nichols Jr. M.D. | University | 11-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 23-1949 | Loudon Park Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams M.D. | Mamie B. Syffer | 1600 W. North Ave |

VS 150

correct age is especially important. Physician please write the cause of death plainly, using only words which are commonly understood.

8 0a

G80077

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80077

BIRTH NO. ANNIE

1. NAME OF DECEASED (Type or Print): Annie L Witzgall

2. DATE OF DEATH: Nov 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: A. A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): Magothy Beach, Severna Pk.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | May 11-1884 | 65 63 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto City
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Myers.
14. MOTHER'S MAIDEN NAME: Rachel Breed
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Walter Witzgall ADDRESS: Severna Park

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis, acute,
DUE TO
(B) Arteriosclerotic cardio-vascular disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) 9 hours
(B) appx 5 yrs
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 19 19 49 *to* Nov 19 19 49 *that I last saw the deceased alive on* Nov 19, 1949, *and that death occurred at* 12 30 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Jos Shear M. D.
23B. ADDRESS: West Balto Gen Hosp
23C. DATE SIGNED: 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-23-49
24C. NAME OF CEMETERY OR CREMATORY: Balto Cem.
24D. LOCATION (City, town, or county) (State): E. N. Ave.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Edward Foulson ADDRESS: Wash Blvd

VS 150

93D

correct age is especially important. Physicians: please fill the blanks carefully and legibly.

G80078

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

2 89.2 G80078

Registered No.

1. NAME OF DECEASED (Type or Print): Edmund Ford ?

2. DATE OF DEATH: November 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 35 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 563 Presstman St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 4-18-86 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Barber | For Self | Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unkown | Unkown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute porphyria | ? |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-17, 1949 *to* 11-17, 1949, *that I last saw the deceased alive on* 11-17, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip J. Negley, M. D. | JOHNS HOPKINS HOSPITAL | 11-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II-22-1949 | Mt Arburn Cem. | Baltimore City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | Elroy O. Wilson 1000 Brantly Avenue |

VS 150

71

correct age is especially important

G80079

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80079

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mollie Dempsey

2. DATE OF DEATH: II-I9-I949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): II7 North Wolfe Street

C. Length of stay in Baltimore I0 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): II7 North Wolfe Street 6-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widowed | I2-25-I890 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Tillery North Carolina | U.S.A. |

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Mary Rendy Harris

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Arbelia Keith | II7 North Wolfe St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) acute Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

(B) Carbuncle of back. — 10 days

DUE TO

(C) Diabetis Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/16 19 49 *to* 11/19 19 49, *that I last saw the deceased alive on* 11/18 19 49, *and that death occurred at* 8 52 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dan Saunders M. D. | 14 W. See | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II-23-I949 | Mt Calvery Cemetary | Brooklyn A.A.Co. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Elroy O. Wilson

ADDRESS: I000 Brantly Avenue

VS 150

61

G80080

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80080

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stephen Heim

2. DATE OF DEATH: Nov. 19-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 421 N. Madeira St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 6-03

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 421 N. Madeira St

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct. 24-1858 | 91 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | BALTO. City | Germany | |

13. FATHER'S NAME: Heim

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Eliza. Heim | 421 N. Madeira St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma right ear — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

(B) (skin of outer ear) — (over)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 4, 1949, *to* Nov 19, 1949 *that I last saw the deceased alive on* Nov 18, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph Pokorny M. D. | 2200 E Madison St 5 | Nov 20 49 |

| 24A. BURIAL / CREMATION / REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 22-49 | Holy Redeemer Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | John H. Miller | 2334 Jefferson Ave. |

VS 150

53

correct age is especially important. Physicians, please write the exact

G80081

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80081

BIRTH NO.

Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | ROBERT E. EBERT |
| 2. DATE OF DEATH | Nov. 19, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 3609 Gwynn Oak Ave. |
| C. Length of stay in Baltimore | 35 yrs. (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 3609 Gwynn Oak Ave. |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Jan. 17, 1885 |
| 9. AGE (In years last birthday) | 64 yrs. |
| If Under 1 Year: Months / Days | |
| If Under 24 Hours: Hours / Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Clerk Freight Rate |
| 10B. KIND OF BUSINESS OR INDUSTRY | B. & O. R. R. |
| 11. BIRTHPLACE (State or foreign country) | Frederick, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Wm. Ebert |
| 14. MOTHER'S MAIDEN NAME | Emma Staley |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | Mrs. Emma F. Ebert |
| ADDRESS | 3609 Gwynn Oak Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | Hours |
| DUE TO (B) | Coronary Insufficiency | 3 yrs |
| DUE TO (C) | Anterior attack | 3 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (Hypertension Cardiovascular Renal Disease & Myocarditis) | 3 yrs |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* Nov — , 19[illegible], *to* Nov 19 , 1949, *that I last saw the deceased alive on* Nov 18, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| Wm. Thos. J. A. Ebert M. D. | 4509 Forty Wright Rd | 11-21-49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
| Burial | 11/22/49 | Lorraine Cem. | Woodlawn, Md. | |

| | | | |
|---|---|---|---|
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
| NOV 21 1949 | Hunter for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

930

G80082

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 976.0

Registered No. G80082

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (D.J.N) CYRUS L. BACON N-853.4

2. DATE OF DEATH November 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3210 Walbrook Avenue

C. Length of stay in Baltimore 27-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3210 Walbrook Avenue 15-06

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Oct. 17, 1905

9. AGE (In years last birthday) (DJN) 44
If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman

10B. KIND OF BUSINESS OR INDUSTRY Porcelain Enamel Specialty Inc.

11. BIRTHPLACE (State or foreign country) W.Va.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Nathaniel Bacon

14. MOTHER'S MAIDEN NAME Malvina Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Elizabeth S. Bacon ADDRESS 3210 Walbrook

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of brain — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3210 Walbrook Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-18-49 8 A. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE Emil L. Beyer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 11-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11-22-49

24C. NAME OF CEMETERY OR CREMATORY New Cathedral

24D. LOCATION (City, town, or county) Baltimore (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 21 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR G. Howard Strong ADDRESS 3207 W. North Ave.,

164c

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G80083

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80083 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James A. La Fontaine
2. DATE OF DEATH: 11-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland general Hospital
C. Length of stay in Baltimore: 2 months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Washington D.C.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington
D. STREET ADDRESS (If rural, give location): 470 Maryland Avenue S.W.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 3-12-1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Broker | | Wash D.C. | USA |

13. FATHER'S NAME: James
14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Charles E Ford | Washington D.C. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebrovascular accident (hemorrhage?) | 5 days |
| DUE TO | generalized arteriosclerosis<br>cerebral arteriosclerosis<br>Arteriosclerotic heart disease | ? |
| (B) | Hypertensive cardiovascular renal disease | |
| DUE TO | chronic congestive failure<br>coronary artery disease | ? |
| (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes mellitus, mild

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-22-49, 19__, *to* 11-21, 1949, *that I last saw the deceased alive on* 11-21, 1949 *and that death occurred at* 12.55 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Candler M.D. | Maryland General Hospital | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Congressional Cem. | Wash. D.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 21 1949 | Thurlington Williams, M.D. | Henry W. Jenkins & Sons Co. | 4905 York Rd |

VS 150

61

correct age is especially important. Physicians: please write the cause

G80084

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.0

G80084

Registered No.

1. NAME OF DECEASED (Type or Print): George LANG

2. DATE OF DEATH: 11-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 49 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-07
D. STREET ADDRESS (If rural, give location): 2926 Christopher Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Caac. | M | 7-3-1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Personnel Mgr. | Bakery | Balto, Md. | U.S.A |

13. FATHER'S NAME: Conrad Lang

14. MOTHER'S MAIDEN NAME: Amelia Lange

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 215-05-1592 | Mrs. Shirley R. Lang | 2926 Christopher Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

(B) Arteriosclerotic Ht Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-19, 1949 *to* 11-20, 1949, *that I last saw the deceased alive on* 11-20, 1949, *and that death occurred at* 5:25 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ruth Bleier M. D. | Sinai Hosp | 11-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 24 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

correct age is especially important. Physicians, please

93D

G80085

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80085

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith Sybil Myers

2. DATE OF DEATH: Nov 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills, Md.
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Nov 19, 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Virginia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Malachoi Higgs | Josephine (?) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | none | Union Memorial Hospital Records |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary arteriosclerosis

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 13, 1949, *to* Nov 20, 1949, *that I last saw the deceased alive on* Nov. 20, 1949, *and that death occurred at* 11 Es P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A. Ramsay M. D. | Union Memorial Hospital | Nov. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 21 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

VS 150

94a

correct age is especially important. Physicians: please write plainly. Use ink.

G80086 ✓ X G80086

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 151

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN FRANK FOSTER

2. DATE OF DEATH Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 3 1st St.
C. Length of stay in Baltimore 84 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Bargall
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Manchester
D. STREET ADDRESS (If rural, give location) RFD

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Wid. | 1/24/65 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md. | USA |

13. FATHER'S NAME John Foster

14. MOTHER'S MAIDEN NAME Frances Hall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| ? | ? | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of stomach | Unknown |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Carcinoma of rectum with metastasis to liver and regional nodes | Unknown |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Aug. 29 1949 *to* Nov. 21 1949 *that I last saw the deceased alive on* Nov. 21 1949 *and that death occurred at* 11:40 AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto. Md. | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 27, 1949 | West Gottingham | Colora, Cecil Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 21 1949 | | J. E. Tyson. Rising Sun, Md |

VS 150

Wintergreen Williamsport, Md

46B

correct age is especially important. Physicians: please write the cause to death in plain English

Lineglos

G80087

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153 Registered No. G80087

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna L. Paff

2. DATE OF DEATH: Nov. 18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2252 N. Duncan St.

c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6.03
D. STREET ADDRESS (If rural, give location): 225 N. Duncan St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Dec 8, 1899 | 49 48 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Moudry

14. MOTHER'S MAIDEN NAME: Mary Moncova

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harry B. Paff ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Intestinal Obstruction | acute |
| DUE TO (B) | Carcinoma of lower bowel | 6 mos. |
| DUE TO (C) | with metastasis | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Oct. 1949

19B. MAJOR FINDINGS OF OPERATION: Carcinoma of lower bowel with metastasis.

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1949, *to* Nov. 18, 1949, *that I last saw the deceased alive on* Nov. 18, 1949, *and that death occurred at* 8:30 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. L. Gamble M. D.

23B. ADDRESS: 200 N. Paca St

23C. DATE SIGNED: 11/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-22-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 21 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: Frank Brockbank ADDRESS: 2004 Eberter

46E

680038

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

163 Registered No. 680038

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD MARCUM LYNCH

2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 2525 S. Carroll St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 5/26/96 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Seafarer | Iowa | USA |

13. FATHER'S NAME: Edward Lynch

14. MOTHER'S MAIDEN NAME: Elizabeth Hipler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| ? | | ? | Records- US Marine Hospital, Balto, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma left lung | over 6 mos |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Bronchopneumonia right and left lungs | (recent) |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Sept. 15, 1949 *to* Nov. 21, 1949, *that I last saw the deceased alive on* Nov. 21, 1949 *and that death occurred at* 6:30A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov 23, 1949 | PHILA. CREMATORY | PHILA. PA |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 22 1949 | Registrar for Williams, M.D. | E. Howard Ammant 5118 Ridgewood Ave |

VS 150

47D

880089 Wood-✓X 680089

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ruth Ellen Wood

2. DATE OF DEATH: November 21 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1400 W. Lexington St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aged Women's and Aged Men's Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Calvert Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | March 12 1869 | 80 | 8 | 9 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Maryland | |

13. FATHER'S NAME: Henry Fletcher Lane.

14. MOTHER'S MAIDEN NAME: Mary Priscilla Fowler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: E. H. Read ADDRESS: 1400 West Lexington St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 24 hrs |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive Cardio-Vascular Disease | yrs? |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* November 20, 1949, *to* Nov 21, 1949 *that I last saw the deceased alive on* Nov 20, 1949, *and that death occurred at* 8.00 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maryland Edward Day M. D. | 4-E-33rd St - Balto 18 | Nov Nov 21 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) |
|---|---|---|---|
| Burial | 11/23/49 | Mt Harmony | Calvert Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Wilson & Dove | 1219 E Fort Ave |

VS 150

937

G80090

BIRTH NO. 49-24492

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9-21-0

G80090 Registered No.

1. NAME OF DECEASED (Type or Print): BABY BURNS N-933

2. DATE OF DEATH: November 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2036 E. Eager Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2036 E. Eager Street 2-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Single | Nov. 8, 1949 | | | 2 | 10 | 30 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USa

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Edith Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT ADDRESS: EDITH BURNS, 2036 E. Eagel St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia
DUE TO laryngeal edema and aspiration of mucous
(B) Prematurity (weight 3 lbs.)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: R S Fisher, M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State)
NOV 16 1949

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1951 ✓

80091

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-25145 — Registered No. 680091

1. NAME OF DECEASED (Type or Print): BABY GIRL COLLINS

2. DATE OF DEATH: 11-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
c. Length of stay in Baltimore: 1 Day

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 8-21
D. STREET ADDRESS (If rural, give location): 2710 PELHAM AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | SINGLE | 11-20-49 | | | 1 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ENFANT
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: STEPHEN COLLINS
14. MOTHER'S MAIDEN NAME: ELIZABETH ICNORR
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: —
17. INFORMANT: — ADDRESS: —

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) ASPIRATION LUNGS | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) HARELIP + CLEFT PALATE | |
| DUE TO | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) CONGENITAL | |
| | CLUBBED HANDS + FEET | |

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 11-20, 1949 *to* 11-21, 1949 *that I last saw the deceased alive on* 11-21, 1949, *and that death occurred at* 2:14 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: James A. Roberts M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 11-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 22, 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Schumacher Funeral Home Inc. ADDRESS:

VS 150

Correct also if deceased is expected to survive. Physicians: please write plainly.

1579

80092 ✓002 G-80092

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G 80092

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Willie Williams

2. DATE OF DEATH: Nov. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 801 Buren St.

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 18 W. 20th St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | single | ? | 39 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?

10B. KIND OF BUSINESS OR INDUSTRY: ?

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): -
(If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT (brother) ADDRESS: Ramsbay, Pa.
Joe Williams-118 So.6th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-8-, 1949 *to* 8-10-, 1949 *that I last saw the deceased alive on* 8-10-, 1949 *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Neil MacMurchy, M.D.

23B. ADDRESS: 801 Buren St.

23C. DATE SIGNED: 11/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL NOV 21 1949

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: 11/22/49

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS:

VS 150

12-B

S0093 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

Registered No. S0093

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SIMON W GROTT

2. DATE OF DEATH November 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 40 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2103 Callow Avenue 13-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | | France | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Not Known | Not Known |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Fannie Grott | 2103 Callow Ave |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemorrhage | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Cerebral arteriosclerosis | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| B S Fuhrman M.D. | | Nov. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-22-49 | Hebrew Friendship | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Jack Rewis Inc | 2100 Eutaw Pl |

VS 151

830

correct age is especially important. Physicians: please write the cause of death in terms understandable to laymen.

G80094

M M 108461

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.1

Registered No. G80097

1. NAME OF DECEASED (Type or Print) William Browning.

2. DATE OF DEATH 11-11-1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave,

b. Length of stay in Baltimore 45, Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 919 Granaby St. 3-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single. | Feb. 5, 1863 | 86 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) New York.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick (D)

14. MOTHER'S MAIDEN NAME Johanna Korlkler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Records B. C. H. 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) hypertensive cardiovascular disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic bronchitis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 2-14-47, 19__, *to* 11-11-, 19 49 *that I last saw the deceased alive on* 11-11- 19 49 *and that death occurred at* 5.00 AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Rogers M. D. | 4940 Eastern ave. | 11-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 21 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Commissioner of Health |

VS 150

93D

correct age is especially important. Physicians: please write plainly.

FS 432931

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80095

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Steve Brown

2. DATE OF DEATH 11-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals
c. Length of stay in Baltimore 20 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 808 E. Lexington Street.

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec. 3, 1899
9. AGE (In years last birthday) 49 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME (D)
14. MOTHER'S MAIDEN NAME (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS 4940 RECORDS BALTO. CITY HOSPITALS EASTERN AVE.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Far Advanced Pulmonary Tuberculosis | |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-26, 19 49 *to* 11-10, 19 49 *that I last saw the deceased alive on* 11-10 1949, *and that death occurred at* 7:50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE H. A. Logan M. D.
23B. ADDRESS 4940 Eastern Avenue
23C. DATE SIGNED 11-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State)

UNIVERSITY MEDICAL SCHOOL NOV 21 1949
Commissioner of Health

DATE RECEIVED BY LOCAL REGISTRAR NOV 22 1949
REGISTRAR'S SIGNATURE Evelyn Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS

VS 150

130

680096

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680096

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John A. Weil

2. DATE OF DEATH: November 21 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1406 Greenmount Ave
C. Length of stay in Baltimore: 33 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 10-01
D. STREET ADDRESS (If rural, give location): 1406 Greenmount Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | June 22 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor | Hopkins Hospital | Pennsylvania | U. S. |

13. FATHER'S NAME: John Weil

14. MOTHER'S MAIDEN NAME: Isaak Schultz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 216-22-9754 | wife Mrs. Sophia Weil | 1406 Greenmount Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Cardio-Vascular Disease with Cerebral Sclerosis | 2 yrs. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Mar. 1949 to Nov. 21 1949 that I last saw the deceased alive on Nov. 19 1949, and that death occurred at 12:15 P m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M. D. | 701 Sheridan Rd. | Nov. 22, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Maryland Memorial Park Cemetery | Baltimore Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | J. Walter Coskin | 2373 Harford Rd. |

VS 150

937

G80097

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

593

G80097

Registered No.

STATE NO.

1. NAME OF DECEASED (Type or Print) Bertha Quarles

2. DATE OF DEATH 11-18-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 511 Otterbein St.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 511 Otterbein Street 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Sept. 20-1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Annapolis - Md. | |

13. FATHER'S NAME James R. Brackett

14. MOTHER'S MAIDEN NAME Elmira Colburn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Isabel Pinto | 213 N. 25th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Auricular Fibrillation | one year |
| DUE TO (B) | Hypertension | 2 years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Nephritis. | 1 month |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 29 1948 *to* Nov 18, 1949 *that I last saw the deceased alive on* Nov 18, 1949 *and that death occurred at* 10:45 p.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Hoke M. D. | 517 Scott St. | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 23, 1949 | Glen Haven | Annapolis Blvd. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, Md | John C. Miller Inc. | 2435 E. Oliver St |

VS 150

131a

G80098

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.1

Registered No. G80098

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Clifton J. Thorn

2. DATE OF DEATH 11-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3203 Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3203 Maryland 27-44

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 23-1896 | 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Engr.

10B. KIND OF BUSINESS OR INDUSTRY Power Company

11. BIRTHPLACE (State or foreign country) Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William H. Thorn

14. MOTHER'S MAIDEN NAME Carrie Ann Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-10-0913

17. INFORMANT Adelphus Thorn ADDRESS 3203 Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Coronary Arteriosclerosis

DUE TO

(C) Hypertension

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug, 1946 *to* Nov 20, 1949, *that I last saw the deceased alive on* Nov. 20, 1949, *and that death occurred at* 3:30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lester Lebo M. D. | 705 Med. Arts Bldg. | Nov 21, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11-22-49 | Lakewood | Taylor Ave - Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Per Instruction for Williams, M.D. | John C. Pilley Inc | 2455 E. Oliver St |

VS 150

94a

680099

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

154 680099 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. AVIS E. EWING
2. DATE OF DEATH: 19 NOV. 1949

3. PLACE OF DEATH: X Baltimore City, Maryland
a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1900 E. 31st St. 9-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | divorced | Dec. 1884 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Baltimore City, Md. | USA |

13. FATHER'S NAME: Charles J. McCormick
14. MOTHER'S MAIDEN NAME: Ella J. Lambright

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mrs. Arthur J. McCormick — ADDRESS: 4404 Glenmore Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized Peritonitis | few days |
| DUE TO | Carcinoma of Rectum | months |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | & Perforation of Bowel | ? |
| DUE TO | and Perforation of Bladder | ? |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arthritis Deformans | 10 yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9 NOV. 49 | Carcinoma of Rectum | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1 NOV 1949 *to* 19 NOV. 1949, *that I last saw the deceased alive on* 5 PM 14 Nov. 1949, *and that death occurred at* 5 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Lacy Morrow M. D. | West Balto. Gen. Hosp. | Nov. 19 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/22/49 | Parkwood | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Lasocka Funeral Home | 7401 Belair Rd. |

VS 150

467

G80:00 ✓ 420.0 G80:00

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Oliver V. Hammel

2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1161 Carroll St. 7-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | widower | | 88 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Platform worker | B. & O. R.R. | Baltimore City, Md. | USA |

13. FATHER'S NAME: Valentine Hammel

14. MOTHER'S MAIDEN NAME: Mary E. Kreutzer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Daniel Dolan | 3833 Lewin Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Generalized arteriosclerosis | years |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerotic Heart Disease | years |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| B B Fisher M.D | ☒ | Nov. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/23/49 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Thurlington Williams, M.D. | Lasseter Funeral Home | 7401 Belair Rd |

correct age is especially important. Physicians, please write all items plainly.

VS 151

93D ✓

680:07 680:07

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William A. Selway

2. DATE OF DEATH: 11/20/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 35 E Montgomery

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE
b. COUNTY 35 E Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md.
d. STREET ADDRESS (If rural, give location) 35 E. Montgomery 22-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | M. | 11/27/1899 | 59 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Packer Tiller | | Baltimore Md | U.S.A. |

13. FATHER'S NAME: John T. Selway

14. MOTHER'S MAIDEN NAME: Cora Eisel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-4207

17. INFORMANT: Mrs. H. A. Selway ADDRESS: same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) arteriosclerosis — 6 mos

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/19/49 *to* 11/20/49, *that I last saw the deceased alive on* 11/20/49 *and that death occurred at* 9:30 A.M., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Isaac Tuller M. D. | 2110 Clark St | 11/21/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 11/23/49 | Western Cem. | Edmondson Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams M.D. | J. J. Fahey Sons | 318 Light St |

VS 150

94a

G80102

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80102

1. NAME OF DECEASED (Type or Print): IDA STARR

2. DATE OF DEATH: Nov. 21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1520 N. Carey St.
C. Length of stay in Baltimore: 30 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mayland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1520 N. Carey Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

13. FATHER'S NAME: Alexander Weitzman

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Alexander Starr | 1520 N. Carey Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: known duration 4 days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Nov-17-1949 *to* Nov. 21, 1949, *that I last saw the deceased alive on* Nov. 17, 1949 *and that death occurred at* 4 05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. Herman Seidel M. D. | 2404 Eutaw Pl. | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-23-49 | Ohr-Knesseth Israel | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Sol. Ellison & Bro. | 1126 W. North Ave. |

VS 150

94a

G80:03 ✓ 420.0 G80:03

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry M Rosenthal

2. DATE OF DEATH 11/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3625 W Garrison Ave 27-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M | June 29, 1902 | 47 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Barber | Own Business | Baltimore Md | |

13. FATHER'S NAME: Joseph Rosenthal

14. MOTHER'S MAIDEN NAME: Rae Dorf

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Fred Rosenthal | 3625 W Garrison Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Myocardial Infarction

DUE TO

(C) Coronary Occlusion

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(D) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-16, 1949 *to* 11/21/49, 19__, *that I last saw the deceased alive on* 11/21, 1949, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leon S. Kaufman M. D. | Sinai Hospital | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Nov 22, 1949 | Hebrew Herring Run Cem | Baltimore | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

93D

correct age is especially important. Physicians, please write the

G80:04

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450.1

Registered No. G80:04

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DORA HORWITZ

2. DATE OF DEATH: NOV. 21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4618 Pimlico Rd.

c. Length of stay in Baltimore: 55 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4618 Pimlico Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

13. FATHER'S NAME: Hyman Shael

14. MOTHER'S MAIDEN NAME: Leba

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mrs. Sara Leavey ADDRESS: 4618 Pimlico Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis Generalized — (INTERVAL BETWEEN ONSET AND DEATH) 1 year

DUE TO

(B) Gangrene - abdominal wall left buttock & left thigh — 2 wks.
DUE TO arteriosclerotic

(C) Senility - ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* December 1, 1948, *to* Nov 21, 1949, *that I last saw the deceased alive on* Nov 21, 1949, *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Weston E. Lowman M. D. | 4643 Park Heights Ave | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 22/49 | Anshei Emunah | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Sol. Levinson & Bro. | 1124-26 W. North Ave. |

VS 150

97

C80:05

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80:05

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Belle Eisenberg

2. DATE OF DEATH Nov. 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Mount Home

C. Length of stay in Baltimore 43 Yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12
D. STREET ADDRESS (If rural, give location) 2907 Springhill Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | 1877 | 72 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Abraham Kessler | Ida ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Aaron Eisenberg | 3723 Towanda Ave |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary atherosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

ANTECEDENT CAUSES

(B) Diabetes Mellitus — ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 1948 19__, to 11-22, 1949, that I last saw the deceased alive on 11-22, 1949, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3200 Eutaw Pl | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-23-49 | Bnai Israel Corp. | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Sol. Levinson & Bros. | 1124-26 W. North Avenue |

VS 150 —

61

680:06 (2) ✓ 680:06

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George Matthew Backert

2. DATE OF DEATH: November 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltirore
D. STREET ADDRESS (If rural, give location): 314 S. Bouldin Street 24 10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 3/19/92 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Maintenance | Rustless Irone & Steel | Baltirore | |

13. FATHER'S NAME: George M. Packert

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Mabel Backert | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Aneurysm of aorta | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Cirrhosis of liver | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/19/49, 19__, *to* 11/21/49, 19__, *that I last saw the deceased alive on* 11/21/49, 19__, *and that death occurred at* 7:11A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maddeus Swinside M. D. | St. Joseph's Hosp. | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 23.49 | Oak Lawn Cemetery | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | John G. Connelly | 418 Eastern Ave. |

VS 150

Correct Age is especially important. Physicians: please write medical terms plainly.

307

G80:07

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80:07

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Eliza Torney

2. DATE OF DEATH: Nov. 20, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 631 W. Lee St.

c. Length of stay in Baltimore: 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 631 W. Lee St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Calvert County, Md. | U.S.A. |

13. FATHER'S NAME: William Hawkins

14. MOTHER'S MAIDEN NAME: Annie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Robert Torney, 631 W. Lee St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 8 Days

DUE TO

(B) Cardio Renal Disease — Interval between onset and death: Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-12, 1949 *to* 11-20, 1949 *that I last saw the deceased alive on* 11-19, 1949, *and that death occurred at* 5:00 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard H. Hurst M. D. | 1631 W. Franklin | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 11-25-49 | Mt Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington for Williams, M.D. | James A. Stayer | 638 N. Gilmor St |

VS 150

131a

680:08

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 3327

680:08

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | SARAH E. LEHNERT |
| 2. DATE OF DEATH | Nov. 20, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 1035 Ashburton St. |
| C. Length of stay in Baltimore | Yrs. Mos. Days |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 227 S. Fremont Ave. 22-07 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | May 5, 1871 | 78 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | own home | Carroll Co., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Hanson McQuay | Elizabeth Brown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Mr. George R. Lehnert Sr. | 1035 Ashburton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Generalized arteriosclerosis — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 1947 *to* Nov. 20, 1949, *that I last saw the deceased alive on* Nov. 19, 1949, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas B. Schreiber M. D. | 54 S. Fulton Ave. | Nov. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

830

680:09

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680:09

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH HAMMEL

2. DATE OF DEATH November 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Baltimore City Hospital

c. Length of stay in Baltimore 25 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3326 E. Baltimore Street 26-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Married | | 56 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Motorman | United R. Co. | N.Y. | U.S. |

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Helen W. Hammel | 3326 E. Balto. St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary occlusion, due | |
| DUE TO | to calcific sclerosis | |
| (B) | of aorta. | |
| DUE TO | | |
| (C) | | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George A. Merrill M.D. | | Nov. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 23/49 | Loudon Park | 3801 Frederick Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-23-1949 | Huntington Williams, M.D. | John O. Mitchell & Sons | 1900 Eutaw Place |

VS 151

94a

correct age is especially important. Physicians: please write the cause of death in plain English—avoid abbreviations.

680110

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680110

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (Charles Albert Kauffman) Albert C. Kaufman

2. DATE OF DEATH 11-20-49

3. PLACE OF DEATH: Baltimore City, Maryland University Hospital

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University

b. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-44
D. STREET ADDRESS (If rural, give location) 3002 Echodale Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 28, 1881 | 67 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| real estate broker | R. Estate | Parkton, Maryland | U.S. |

13. FATHER'S NAME: William F. Kauffman

14. MOTHER'S MAIDEN NAME: Elizabeth Carroll

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Ada F. Kauffman | 3002 Echodale Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Vascular Thrombosis | |
| DUE TO (B) | Terminal Pneumonia | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-20, 19 49 *to* 11-20, 19 49 *that I last saw the deceased alive on* 11-20, 19 49, *and that death occurred at* 3:45 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph McKinney M. D. | Univ. Hosp. | 11-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 23/49 | Lorraine Cemetery | Frankelistown Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | John J. Mitchell & Sons | 1900 Eutaw Place |

VS 150

836

correct age is especially important. Physicians: please write the causes of death clearly. Type or print plainly.

CERTIFICATE CORRECTED 11-29-49

G80:11

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80:11

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): EDWARD F. DIVEN

2. DATE OF DEATH: II/19/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — I433 Battery Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I433 Battery Avenue 24-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | I/7/1897 1898 | 52 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard | Maritime | Baltimore | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank | Delia ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes | | Family - | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Hypertensive Cardio - Vascular Disease — DUE TO

(B) Chronic nephritis — DUE TO

(C) Terminal uremia

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3-4 yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | 11/21 |

22. *I hereby certify that I attended the deceased from* 1948, 19__, *to* 1949, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 107 E. West St. | 11/22 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | II/23/49 | Holy Rosary | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | James L. McCaney | 130 E. Fort Ave. |

VS 150

131a

CSD:12

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-15793 — Registered No. CSD:12

1. NAME OF DECEASED (Type or Print): John S Stoll (JOHN WAYNE STOLL)

2. DATE OF DEATH: November 21 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8 or
D. STREET ADDRESS (If rural, give location): 1723 N. Patterson Park Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Child | 7-26-49 | 0 | 3 | 25 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Harry S Stoll
14. MOTHER'S MAIDEN NAME: Mary M. Boone
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr & Mrs Harry S. Stoll — ADDRESS: 1723 N. Patterson Pk. Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Cong. renal anomaly
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-21, 1949 *to* 11-21, 1949 *that I last saw the deceased alive on* 11-21, 1949 *and that death occurred at* 5:15 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Bruce Blackfan M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 11-21-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/23/49 | Moreland Memorial Cem. | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR — ADDRESS: HENRY SANDER & SONS, INC.

VS 150

157H

correct age is especially important. Physicians: please write the cause of death plainly.

G80133

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. G80133 Registered No.

1. NAME OF DECEASED (Type or Print): WILLIE WILLIAMS (dim)

2. DATE OF DEATH: November 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1408 Pennsylvania Avenue 14-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widowed | March 19 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mgr. Penny Arcade | | North Carolina | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Willie Williams | Mary ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic cardiovascular disease | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| C. J. Smith M.D | ☐ / ☐ / ☒ | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-26-49 | Mt. Auburn | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | William A. Jackson 916 Pennsylvania Ave 937 |

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80:14

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 23

Registered No. G80:14

BIRTH NO.

1. NAME OF DECEASED (Type or Print) W. CLIFTON (SPENCER) SPENCE

2. DATE OF DEATH November 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 414 N. Dallas Street 6-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | DIVORCED | MAR. 5-1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) BALTO. MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME NOAH SPENCE

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES

(If yes, give war or dates of service) WAR 1

16. SOCIAL SECURITY NO

17. INFORMANT ESTELLE JACKSON ADDRESS 414 DALLAS ST.

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 8 months
DUE TO aortic insufficiency

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary insufficiency — unknown
DUE TO

(C) Syphilitic aortitis — unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE George G. Mcneill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Nov. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL

24D. LOCATION (City, town, or county) BALTO. (State) MD.

DATE RECEIVED BY LOCAL REGISTRAR NOV 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR WILLIAM A. JACKSON ADDRESS 916 PENNA AVE

VS 151

30

G80115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

Registered No. G80115

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josephine Valenti

2. DATE OF DEATH Nov. 21, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 907 Fawn St.

c. Length of stay in Baltimore 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 907 Fawn St. 3-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Dec. 24 1888 | 60 | 10 | 28 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hand Finisher on ~~on~~ mens Clothing Factory

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ripeste Italy

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Antonino Musumeci

14. MOTHER'S MAIDEN NAME Lucia Vaccarine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO 214-18-1928

17. INFORMANT Charles Valenti ADDRESS 225 S. Bouldin St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Wm. H. Kammer, M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED Nov. 21, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE November 24/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cems.

24D. LOCATION (City, town, or county) (State) 2430 Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 22 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Frank Della Rocca ADDRESS 322 S. High St

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

937

G80116

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

175

Registered No.

G80116

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Virion Maria Bosta

2. DATE OF DEATH: 11-21-49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital

c. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 8-01
D. STREET ADDRESS (If rural, give location): 2218 Kentucky Ave. - Balto. 13, Md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M. | 6/9/11 | 38 | 5 / 12 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: CARL COLEMAN

14. MOTHER'S MAIDEN NAME: MARY VAN SANT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinoma.

DUE TO

(B) Carcinoma of Ovary.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9-49, 1949 *to* 11-21-49, 1949 *that I last saw the deceased alive on* 11-21-49, 1949, *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. J. Cartellone M. D.

23B. ADDRESS: 2025 W. Fayette.

23C. DATE SIGNED: 11-21-49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 25 1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State): 4420 Belair Rd. Balt. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Frank Della Rocca 322 S. High St.

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680117

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

331

680117 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nehemiah R. Tilson

2. DATE OF DEATH: Nov. 19, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Ave. Bal-Wash Nursing Home

c. Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1317 Madison Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | Feb. 14, 1893 | 56 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Tilson

14. MOTHER'S MAIDEN NAME: Anna Bass

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Dashti B. Tilson ADDRESS 1317 Harlem Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho pneumonia

DUE TO

(B) Cerebral hemorrhage

DUE TO

(C) Hypertension, Enlargement of the heart.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 17, 1949 *to* Nov. 19, 1949, *that I last saw the deceased alive on* Nov. 17, 1949, *and that death occurred at* 12.30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles S. Weintodt M. D.

23B. ADDRESS: 1730 Linden Ave

23C. DATE SIGNED: Nov. 21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 23, 1949

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.

24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Holland Funeral Home

ADDRESS: 1631 Druid Hill Ave.

95c

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G80118 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 581.0 — Registered No. G80118

BIRTH NO.

1. NAME OF DECEASED (Type or Print): YATES PENNINGTON
2. DATE OF DEATH: Nov. 21, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1021 St. Paul St. 11-21
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10/20/97
9. AGE (In years last birthday): 52 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Yates Pennington
14. MOTHER'S MAIDEN NAME: Genevieve Thompson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: ?
17. INFORMANT — ADDRESS: Records- US Marine Hospital, Balto, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage from ruptured esophageal varices. — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.

DUE TO

(B) Laennec's cirrhosis — Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 20, 1949, *to* Nov. 21, 1949, *that I last saw the deceased alive on* Nov. 21, 1949, *and that death occurred at* 2:10 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Victor A. McKusick, M. D.
23B. ADDRESS: US Marine Hospital, Balto. Md.
23C. DATE SIGNED: 11/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/23/49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm. Cook Inc 1217 St. Paul St.

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G80119 ✓ 81.0 G80:19

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ABBIE MAY CARLISLE
2. DATE OF DEATH: 11/20/49
3. PLACE OF DEATH: Baltimore City, Maryland
a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 104 W. FORT AVE
b. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 104 W. FORT AVE 23-01
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG 20, 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: SAMUEL D. REXROTH
14. MOTHER'S MAIDEN NAME: EMMA OVERLANDER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MR JOSEPH E. CARLISLE
ADDRESS: 104 W. FORT AVE. -30

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: 4-5 yrs

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/20, 1949 *to* 11/20, 1949 *that I last saw the deceased alive on* 11/17, 1949 *and that death occurred at* 6:00 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edward L. Harman M. D.
23B. ADDRESS: 4037 Falls Rd.
23C. DATE SIGNED: 11/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 11/23/49
24C. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
24D. LOCATION (City, town, or county) (State): FREDERICK ROAD. MD

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: JOHN F. DENNY, INC
ADDRESS: 715 LIGHT ST -30

VS 150

124B

G80120 X ✓ 260 G80120

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ALBINA GUZIK

2. DATE OF DEATH: 11/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General.
C. Length of stay in Baltimore: Yrs. — Mos. — Days: 8 days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rosemont (Rural Lansdowne)
D. STREET ADDRESS (If rural, give location): 2838 Louisianna Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | April 15, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | Home | Poland | Poland |

13. FATHER'S NAME: Bartholomew Skwirut

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | None | Frank Guzik | Rosemont Lansdowne, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arterio Sclerotic brain disease

DUE TO

(B) diabetes Mellitus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/11/49 *to* 11/19/49, *that I last saw the deceased alive on* 11/19/49 *and that death occurred at* 5 or 8 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D. | 23B. ADDRESS: 1213 Eagle St. | 23C. DATE SIGNED: 11/19/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 3, 1949 | Holy Cross | Brooklyn, A.A. Co., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949

REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.

25. FUNERAL DIRECTOR: Thomas W. Singleton | ADDRESS: Glen Burnie, Md.

VS 150

61

correct age is especially important. Physicians: please write the cause in plain English and legibly.

G80121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178

G80121 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benjamin G. Santilli

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3925 Park Heights Ave.

c. Length of stay in Baltimore: 39 Yrs. XXX

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3925 Park Heights Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan. 17, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tool Maker | Air Craft Mfg. | Italy | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Santilli | ? DiPietro |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | 218-05-7944 | Mrs. I. S. Santilli, 3925 Park Hgts. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Teratoma of Testicle(l) with metastasis to lungs, liver and spleen — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO

(B)

DUE TO

(C) Pulmonary Edema — 1 day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/4/49 | Teratoma of left testicle | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/4/49, 19__ *to* 11/22/49, 19__, *that I last saw the deceased alive on* 11/21/49, 19__, *and that death occurred at* 1:45 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M.D. | 1901 Eutaw Place | 11/ /49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11/25/49 | Holy Redeemer | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | C. Vernon Lemmon, 4611 Park Heights Av. |

VS 150

51C

correct age is especially important. Physicians: please write the causes of death plainly

C80122

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80122

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William H. Coyle

2. DATE OF DEATH: Nov. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pine Ridge Nursing Home, 4703 Hampnett Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 2009 E. Preston St., 8-07

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Aug. 17, 1887
9. AGE (In years last birthday): 62 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeuer
10B. KIND OF BUSINESS OR INDUSTRY: Tin Can Factory
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frederick Coyle
14. MOTHER'S MAIDEN NAME: Elizabeth Hill,
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 215-01-7786
17. INFORMANT: Eliz. Tyler, ADDRESS: 407 Folsom St.

## MEDICAL CERTIFICATION

CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Lobar Pneumonia - | 1 day. |
| | DUE TO (B) - Arterial Hypertension. | 1 yr. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) Chronic Endocarditis - | 1 yr. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan-1, 1949, to 11/20, 1949, *that I last saw the deceased alive on* 11/, 1949, *and that death occurred at* P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1279 William St.,
23C. DATE SIGNED: 11/ /49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 11/23/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: C. Vernon Lemmon, ADDRESS: 4611 Park Heights Ave.

VS 150

108

correct age is especially important. Physicians: please write the cause of death plainly and fill in all items

G80123 X ✓ Prov. 1 G80123

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Doonan, Mr. James

2. DATE OF DEATH November 22 '49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New York
D. STREET ADDRESS (If rural, give location) 142 Fremly Road

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Hosp.

c. Length of stay in Baltimore 1 month (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 27, 1879 | 70 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Doonan Mr. Frank

14. MOTHER'S MAIDEN NAME Barton, Margaret

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Sklez, Mrs. Grace 307 ADDRESS Joppa Rd. Towson Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 17 days

DUE TO

(B) Arteriosclerotic

DUE TO

(C) Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 5, 1949 *to* Nov. 22, 1949 *that I last saw the deceased alive on* Nov. 22, 1949, *and that death occurred at* 9:30 a.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Gilbert M. D. | Church Home + Hosp. | Nov. 22, '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| removal | 11/22/49 | Calvary Queens | New York City, N. Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Wm. Cook, Inc., 1217 St. Paul Street |

VS 150

937

correct age is especially important. Physicians, please write the cause of death in plain English.

G80124

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 972.0

Registered No. G80124

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AGNES RITTER — N-968

2. DATE OF DEATH November 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.,
D. STREET ADDRESS (If rural, give location) 1944 E. Lombard St. 2-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | May-11-1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | "Home" | Balto. Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Fabiuh Gavin | Mary Barrett |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Mary Gavin (Sister) | Louisiana Miss |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation

DUE TO

(B) Carbon Monoxide

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 1944 E. Lombard St. |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| November 19, 1949 ? m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Inhalation of Illuminating gas |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. S. Fisher M.D. | | 11-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 22/49 | Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Evelyn for Williams, M.D. | Sherwood Morris Co. | Balto |

VS 151

163H

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80125

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80125

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Reitz Schott

2. DATE OF DEATH: Nov 21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2221 St Paul St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2221 St Paul Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Jan 22 1862 | 87 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Balto Md | US |

13. FATHER'S NAME: Herman J Reitz

14. MOTHER'S MAIDEN NAME: Louisa Stein

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | no | None | Miss Emma S. Schott Daughter | 2221 St Paul |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration — INTERVAL BETWEEN ONSET AND DEATH: 4 Hours

DUE TO

(B) Arterio Sclerosis — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 13, 1949 *to* Nov 21, 1949 *that I last saw the deceased alive on* Nov 21, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arthur J Davies M. D. | 800 W 33rd St - 11 | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 23/49 | Green Mount | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams M.D. | J. Stewart Moore Co. | Balto Md |

VS 150

correct age is especially important. Physicians: please write plainly. Use ink.

93

G80126

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 yr. 1

G80126

BIRTH NO

Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM ROSS

2. DATE OF DEATH November 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 128 N. Exeter Street 5-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | U | U | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| N | K | K | |

13. FATHER'S NAME N O

14. MOTHER'S MAIDEN NAME N O

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) pulmonary tuberculosis (ostr)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| C. J. Tubman M.D. | | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 21 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 22 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Y. Y. 13B

680:27

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Spicer

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salisbury
D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 8-17-09 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Restaurant Owner | | Del. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ernest Spicer | Della Mitchell |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 30 min

DUE TO

(B)

DUE TO

(C) Tabes dorsalis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/21, 19 49 *to* 11/21, 19 49, *that I last saw the deceased alive on* ____, 19 ____, *and that death occurred at* 7:55 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph D. B. King M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Rural | 11/25/49 | Memorial | Salisbury, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Hill & Johnson | Salisbury, Md. |

VS 150

30a

correct age is especially important. Physicians: please write the cause of death plainly and correctly.

G80:28 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT 153 G80:28

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Anna Matilda Francis

2. DATE OF DEATH Nov-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland. B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson 4

c. Length of stay in Baltimore 64 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 309 W. Joppa Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | widowed | March 13 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | |

13. FATHER'S NAME Mr. Henry Kaline

14. MOTHER'S MAIDEN NAME Anna Scholl

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Catherine Francis | 309 Joppa Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adom Generalized Carcinomatosis

DUE TO

(B) Adenocarcinoma of Colon

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-30-49 | Abdominal Carcinomatosis from Colon | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 9 19 49 *to* Nov 22, 19 49 *that I last saw the deceased alive on* Nov 22, 19 49, *and that death occurred at* 12 29 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul C. Gordon M.D. M. D. | Union Memorial Hospital | Nov 22 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Prospect Hill | Towson MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Tillman & Son Inc | 1217 E. Lexington St |

VS 150

46E

copyright law, especially important. Physicians, please write the cause of death in such a way that it may be clearly understood

G80:29

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-82394

Registered No. G80:29

1. NAME OF DECEASED (Type or Print): Barry Leroy Johnson

2. DATE OF DEATH: 10-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1703 Druid Hill Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 6 Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | | 10-14-49 | | | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Henry Johnson | Louise Lebrich Harris |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aspiration Pneumonia
DUE TO
(B) Atelectasis - Pulmonary
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-19-49 *to* 10-24-49, *that I last saw the deceased alive on* 10-24-49, *and that death occurred at* 9:15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert L. Worley M. D. | Provident Hosp | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL NOV 22 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, MD | Commissioner of Health | |

VS 150

107

correct age is especially important. Physicians: please write the cause of death plainly and fill in all items completely.

680130 BALTIMORE CITY HEALTH DEPARTMENT 680130

# CERTIFICATE OF DEATH

BIRTH NO. 49-24254 Registered No.

1. NAME OF DECEASED (Type or Print): Gregory Ronnie Nesbitt
2. DATE OF DEATH: 11-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: 2 (Yrs / Mos / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 105 Hendricks Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Negro | | 11-12-4 | | | 2 / 40 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md. | |

13. FATHER'S NAME: William Nesbitt Jr.
14. MOTHER'S MAIDEN NAME: Diana Mae Harten

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | 105 Hendrick Ct |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Atelectasis | |
| DUE TO | (B) Cerebral Hemmorhage | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/12/1949 *to* 11/14/1949 *that I last saw the deceased alive on* 11/14/1949 *and that death occurred at* 3 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maryland D. Jones M. D. | 1300 N. Fremont | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL | NOV 22 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

160a

correct age is especially important. Physicians: please write the cause of death clearly. Use legal

G80131

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-19609 491 Registered No. G80131

1. NAME OF DECEASED (Type or Print): BERNADETTE BROWN

2. DATE OF DEATH: November 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-03
D. STREET ADDRESS (If rural, give location): 1628 W. Mosher Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | | | 3 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Leroy Skides
14. MOTHER'S MAIDEN NAME: Sarah H. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sarah H. Brown, ADDRESS: 1628 Mosher Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Focal pneumonia (bronchopneumonia) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Nov. 22, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11-24-49 | St. Peters Cemetery | Westport Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: 11/23/49
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: ADDRESS: Metropolitan Funeral Home, 927 N. Mount St.

VS 15

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

107

G80132 133591 G80132

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4211

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Taylor (Charles Allen Taylor)

2. DATE OF DEATH: 11-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 47 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05
D. STREET ADDRESS (If rural, give location): 1032 Jefferson St. 2-25

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Wid. | Sept. 11, 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (D)

14. MOTHER'S MAIDEN NAME: (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 212-09-6643

17. INFORMANT: Baltimore City Hospitals Records ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Calcific aortic stenosis due to undetermined etiology

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-19- , 1949 *to* 11-21- , 1949, *that I last saw the deceased alive on* 11-21- , 1949, *and that death occurred at* 9:50 AM *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Organ M. D. | 23B. ADDRESS: B. C. H.--4940 Eastern Ave. | 23C. DATE SIGNED: 11-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Nov 25 49 | 24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn | 24D. LOCATION (City, town, or county) (State): Baltimore City, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949 | REGISTRAR'S SIGNATURE: Deputy for Hortense, M.D. | 25. FUNERAL DIRECTOR: Luther Gross ADDRESS: 1918 Addison Avenue 92a

VS 150

G80133

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

197 Registered No. G80133

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE A. KALBFLEISCH

2. DATE OF DEATH: 11/20/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3312 Foster Avenue
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 3312 Foster Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 10/13/1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Barrell Cooper | Standard Oil Co. | Maryland | U.S.A. |

13. FATHER'S NAME: Henry Kalbfleisch

14. MOTHER'S MAIDEN NAME: Theresa Greiser

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | ? | Henry Kalbfleisch(son) | 3312 Foster Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lumbar region c metastasis. (Sarcoma)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 1, 1949 *to* November 20, 1949 *that I last saw the deceased alive on* Nov. 20, 1949, *and that death occurred at* 12 45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. A. Flanigan Jr. M. D. | 3503 Fait Ave | 11-21-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/1949 | Sacred Heart Cem. | Baltimore County Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Lilly & Zeiler Inc. | 403 S. Wolfe St. Balto. |

VS 150

55R

Correct age is especially important; physicians, please write the cause of death plainly.

G80134

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G80134

1. NAME OF DECEASED (Type or Print): JOHN JOSEPH ROCKSTROH
2. DATE OF DEATH: 11/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen. Hosp.
c. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3710 Hudson Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 2/7/1903 | 46 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Policeman | Retired | Maryland | U.S.A. |

13. FATHER'S NAME: Joseph Rockstroh
14. MOTHER'S MAIDEN NAME: Josephine Grunbauer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | ? | Barbara Rockstroh (wife) | Same |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) GASTRIC HEMORRHAGE
DUE TO
(B) RUPTURED ESOPHAGEAL VARIX
DUE TO
(C) CIRRHOSIS OF LIVER

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
GLOMERULO NEPHRITIS

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/19, 1949 *to* 11/20, 1949 *that I last saw the deceased alive on* 11/20, 1949, *and that death occurred at* 5-20 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William B. Cooper Jr. M. D. | South Balto. General Hosp. | 11/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/1949 | Holy Redeemer | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Lilly & Zeiler Inc. | Baltimore Md. |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

124B

680135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680135

BIRTH NO. 49-42539

1. NAME OF DECEASED (Type or Print): Vera Elizabeth Taylor

2. DATE OF DEATH: 10-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 1311 North ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | | 10-23-49 | | | 6 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. Md. | |

13. FATHER'S NAME: Joseph Hugo Taylor Jr.

14. MOTHER'S MAIDEN NAME: Mary Fisher

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mother | 1311 North Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital Debilitas
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1422 E. Lombard | 11/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL NOV 22 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Commissioner of Health | |

Vs. rec'd

159

G80136

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 97 x 0 G80136 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CAMILLA KEITER — N-968

2. DATE OF DEATH November 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25-43
D. STREET ADDRESS (If rural, give location) 2325 Washington Boulevard

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Dec. 16, 1926 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Receptionist | Helwig & Leach | Baltimore, Md. | |

13. FATHER'S NAME: George Grimm

14. MOTHER'S MAIDEN NAME: Vio, etta Wilson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | William E. Keiter | 2536 Washington Blvd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation, due to inhalation of illuminating-
DUE TO
(B) gas.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2325 Washington Boulevard

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY November 22, 1949 4 a.m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Gas burners on stove open but unlit

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Nov. 22, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Western | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR NOV 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

163 H

680137

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

680137
Registered No.

BIRTH NO. 49-20366

1. NAME OF DECEASED (Type or Print): Johnnie Mae Ross
2. DATE OF DEATH: 9-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 106 N. Gilmor st. 19-04

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): N.B.
8. DATE OF BIRTH: 9-25-49
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.: 22

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Ross
14. MOTHER'S MAIDEN NAME: Esther Mae Cosby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother
ADDRESS: 106 N. Gilmor st.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Sub Arachnoid
DUE TO
(B) hemorrhage
DUE TO
(C) Asphyxia Livida

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-24, 1949 *to* 9-28, 1949, *that I last saw the deceased alive on* 9-28, 1949 *and that death occurred at* 10:34 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert F. Sanders, M. D.
23B. ADDRESS: Provident Hosp
23C. DATE SIGNED: 11-14-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): NOV 22 1949

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949
REGISTRAR'S SIGNATURE: acting for Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

correct age is especially important. Physicians: please write plainly

160a

680138 ✓ X 680138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): HERBERT CLAUDE MINER.

2. DATE OF DEATH: NOV. 22. 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2407 EVERTON ROAD
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MASS.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) READING.
D STREET ADDRESS (If rural, give location) 336 HAVEN ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | SEPT. 16. 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED | STEAM FITTER | EAST HADDEN. CONN. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| — MINER. | AUGUSTUS YOUNG. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| NO. | | MRS H. CLAUDE MINER - 336 HAVEN ST | READING. MASS. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Cerebral hemorrhage | 5 min.? |
| DUE TO | | |
| (B) | Arteriosclerotic heart disease | 4 days |
| DUE TO | | |
| (C) | Acute bronchitis | 4 days. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/18, 1949 *to* 11/22, 1949 *that I last saw the deceased alive on* 11/21, 1949, *and that death occurred at* 8 35 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert A. Reiter M. D. | 340 E Windsor Ave | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| REMOVAL | NOV. 23. 1949 | — | READING. MASS. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Hunting for Williams, M.D. | WM J. TICKNER AND SONS | BALTO. 17. MD. |

VS 150

93D

correct age is especially important. Physicians, please write the causes of death plainly.

G80139 ✓ X G80139

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 420.1
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MR. Raymond See
2. DATE OF DEATH 11/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. THERESA'S BON SECOURS HOSP.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Baltimore
C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township) BALTIMORE Rural
D. STREET ADDRESS (If rural, give location) 5211 GARMOUTH Rd. 29

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | White | | N.Y. 2/2/98 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor | Bakery | N.Y. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frederick See | Martha Tucker ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes World War No. 1 | | Mrs. Florence See | Catonsville, Md 5211 Garmouth Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MASSIVE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Angina Pectoris & Coronary insufficiency — 3 yrs ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/21, 1949, *to* 11/22, 1949, *that I last saw the deceased alive on* 11/21, 1949, *and that death occurred at* 5.40 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William S. Womack M.D. | BON SECOURS HOSP. | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Balto. National Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Thomas [illegible] | WM. J. TICKNER & SONS | Balto., Md. |

correct age is especially important. Physicians: please write the cause of death in plain English — avoid technical terms.

VS 150

94a

G80140

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54.0.0 G80140 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Raymond S. Tompkins

2. DATE OF DEATH: NOV 22 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-15
D. STREET ADDRESS (If rural, give location): 5407 Falls Rd Terrace

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 10-12-90 | 59 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Vice President | Balto Transit Co | N. Y. | |

13. FATHER'S NAME: Charles Edgar Tompkins

14. MOTHER'S MAIDEN NAME: Mary Louise McCort

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT — ADDRESS |
|---|---|---|
| no | 213-05-9796 | Mrs. Mary L. Tompkins 5407 Falls Rd. Terrace |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

DUE TO

(B) Lower nephron nephrosis — 24 hrs

DUE TO

(C) Peritonitis — 48-72 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/16/49 | gastric ulcer and adhesions | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-13, 1949, *to* 11-22-, 1949, *that I last saw the deceased alive on* 11-22-, 1949, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James C. Jardell, Jr., M.D. | JOHNS HOPKINS HOSPITAL | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/24/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 23 1949 | | WM. J. TICKNER & SONS Balto., Md. |

VS 150

117a

correct age is especially important. Physicians are urged to see that all items are properly completed.

680141

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

760 Registered No. 680141

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AMOS BERNARD HARRYMAN

2. DATE OF DEATH: NOV. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Volunteers of America Hospital
c. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto - 1
D. STREET ADDRESS (If rural, give location): 877 N. Howard St. 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | NOV. 20, 1871 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Theatre box office | | Reisterstown, Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| AMOS A. HARRYMAN | Harding |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Emma Harryman | 877 N. Howard St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 10 days |
| DUE TO (B) | Generalized arteriosclerosis | several years |
| DUE TO (C) | Diabetes Mellitus | 6 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* OCT. 31, 1949, to NOV. 22, 1949, *that I last saw the deceased alive on* Nov. 21, 1949, *and that death occurred at* 8.25 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Raymond Lyons, M. D. | Volunteers of America Hosp. | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 25/49 | Lutheran Cemetery | Reisterstown Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Acting for Williams, M.D. | Harry K Ritzle | 1101 Edmondson Ave |

VS 150

61

80:42 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

No. 1 Registered No. 680:42

1. NAME OF DECEASED (Type or Print): Sarah [redacted] Krol l

2. DATE OF DEATH: 11/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. ___ Mos. ___ Days ___

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Relay - 27
D. STREET ADDRESS (If rural, give location): 1731 Magnolia Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Sept. 10, 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse

10B. KIND OF BUSINESS OR INDUSTRY: ___

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ordimus Riggs Zepp. (dec'd)

14. MOTHER'S MAIDEN NAME: Sarah Miller (dec'd)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: ___

17. INFORMANT: Woodrow Krol l — ADDRESS: 1731 Magnolia Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic CVD

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: ___

19B. MAJOR FINDINGS OF OPERATION: ___

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ___

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): ___

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): ___

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: ___

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? ___

22. *I hereby certify that I attended the deceased from* 11/21 19 49 *to* 11/21 19 49 *that I last saw the deceased alive on* 11/21 19 49 *and that death occurred at* 10 45 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Herbert J. Linikos M. D.

23B. ADDRESS: St. Agnes Hospital

23C. DATE SIGNED: 11/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: Nov. 25 49

24C. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE

24D. LOCATION (City, town, or county) (State): DORSEY, MD

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949

REGISTRAR'S SIGNATURE: [illegible] for Millicent, M.D.

25. FUNERAL DIRECTOR: Harry N. Wright — ADDRESS: 4101 Edmondson Ave

VS 150

937

correct age is especially important. Typewrite; please write the cause of death in ink.

C80143

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17°

Registered No. C80143

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bertha Parrott

2. DATE OF DEATH: Nov. 21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 606 N. Augusta Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 63 yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 606 N. Augusta Ave. 16-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | Divorced | June 3, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md. | |

13. FATHER'S NAME: Joseph J. Turner

14. MOTHER'S MAIDEN NAME: Emily J. Griffith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mr. Olive Turner, 606 N. Augusta Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

DUE TO

(B) Paget's disease of left nipple — 9 or 9 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| No operation | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Aug —, 1944, *to* Nov 21, 1949, *that I last saw the deceased alive on* Nov 21, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| McBurney & Lord, M. D. | 2200 Garrison Blvd | Nov 22 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 23/49 | Loudon Pk/ | 3801 Frederick Rd. Balto. md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Harry A. Dietz | 4101 Edmondson Ave. |

VS 150

50

Correct age if specially important. If unknown, state whether presumably over or under 100 years.

G80144

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80144

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charlotte C. Saunders

2. DATE OF DEATH: Nov. 22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 816 Primson Ave.

c. Length of stay in Baltimore: Yrs. Life Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 816 Primson Ave. 25-41

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | Married | March 18, 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H. W. | | Balto. Md. | |

13. FATHER'S NAME: Walsh

14. MOTHER'S MAIDEN NAME: Catherine----- (husband)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Albert T. Saunders, ADDRESS: 816 Primson Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Cervix Uteri — INTERVAL BETWEEN ONSET AND DEATH: 2/1-47

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 2/1-47 | Carcinoma | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 2/1- , 1947 *to* 11/22 , 1947 *that I last saw the deceased alive on* 11/21 , 1949 *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas R Cahn M. D. | 2145 W Baltimore St | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 25/49 | Baltimore National | 5501 Frederick Rd. Balto. MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 19 | Contingent for Williams, M.D. | Harry A. Nitzke | 4101 Edmondson Ave |

VS 150

48a

680145 ✓ 680145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Thomas Scroggins

2. DATE OF DEATH 11/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) President Home.

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 646 N. Calhoun St. 16-0-

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | Colored | Married | May 17 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Prince Wm. Co. Va. | U.S.A. |

13. FATHER'S NAME Henry Scroggins

14. MOTHER'S MAIDEN NAME Mary Gaskins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO.

17. INFORMANT Margaret Scroggins-Calhoun ADDRESS 646 N.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cerebral hemorrhage — 12 days

DUE TO

(C) Hypertension, Essential

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/14, 1949 *to* 11/18, 1949 *that I last saw the deceased alive on* 11/18, 1949 *and that death occurred at* 10 A.M. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lawrence W. Leary, M.D. | President Hosp. | 11/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-23-1949 | Broad Neck Cem. | Broadneck Md. |

DATE RECEIVED BY LOCAL REGISTRAR NOV 23 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 3 L.M.

Correct age is especially important. Physicians: please write the cause of death clearly.

VS 150

83a

C80146

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80146

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JAMES SMALLWOOD

2. DATE OF DEATH: 11/19/X9

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1710 LEMMON ST
C. Length of stay in Baltimore: 15 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 19-03
D. STREET ADDRESS (If rural, give location): 1710 LEMMON ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | COLORED | MARRIED | 7-4-1896 | 53 | 4 | 15 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PAPER HANGER | | KENTUCKY | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JAMES SMALLWOOD | MARTHA ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | | SOPHIE SMALLWOOD | 1710 LEMMON ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: X yrs

DUE TO

(B) AORTIC ANEURYSM — 3 yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* JUNE 15, 19X5, *to* NOV 19, 19X9 *that I last saw the deceased alive on* NOV 3, 19X9, *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. William Frey M. D. | 1928 Penna Ave | Nov 22/X9 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-23-1949 | Mt. Auburn Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV | Penitentiary Physician | Mrs Katie R. Williams | 322 N Schroeder St |

VS 150

30D

Correct age is especially important. If unknown, please write "unknown."

C80147

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80147
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Gillard
2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1406 Ward St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 21-02
D. STREET ADDRESS (If rural, give location): 1406 Ward St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | July 12, 1916 | 33 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Eutawville S.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Myers | Mamie ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Mazie Murray | 1438 Ward St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Genito Urinary Tuberculosis — 6 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-6 *1949, to* 11-21 *1949, that I last saw the deceased alive on* _____, 1949, *and that death occurred at* 2:50 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Julian P. Meredith M.D. | 1227 Washington Blvd | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-25-1949 | Eutawville S.C. | Eutawville S.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | | Mrs Katie R. Williams | 322 N. Schroeder St |

VS 150

13B

G80148 ✓ G80148

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) KENNETH WILSON

2. DATE OF DEATH November 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-01
D. STREET ADDRESS (If rural, give location) 1636 Lorman Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Infant | April 21, 1948 | / | 19 / | / |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Kenneth Wilson

14. MOTHER'S MAIDEN NAME Doris Nurse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Doris Wilson 1636 Lorman St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Interstitial pneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchial asthma | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [✓], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED Nov. 22, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE Nov. 23, 1949

24C. NAME OF CEMETERY OR CREMATORY Evergreen

24D. LOCATION (City, town, or county) (State) Brooklyn, N.Y.

DATE RECEIVED BY LOCAL REGISTRAR Nov 23 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR ADDRESS Holland Funeral Home 1631 Druid Hill Ave.

VS 151

114E ✓

Gen. 66350

G80149

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 443

G80149

Registered No.

1. NAME OF DECEASED (Type or Print): Henry Turner

2. DATE OF DEATH: Nov. 21- 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 10 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 4311 Dewey Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Wid. | June -1- 1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VA.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Turner
14. MOTHER'S MAIDEN NAME: Leah Roberts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: Records B.C.H. 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive cardiovascular disease | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hemipligia, left | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5- 27- 191 *to* 11- 21- 1949, *that I last saw the deceased alive on* 11- 21 19 49, *and that death occurred at* 7.45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Logan M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 11- 21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 26 1949.
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949
REGISTRAR'S SIGNATURE: Deputy Registrar, Md.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 150

93D

G80150

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80150 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM HACKEL

2. DATE OF DEATH: November 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3405 Claremont Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 10, 1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman-retired | City of Baltimore | Baltimore, Md. | |

13. FATHER'S NAME: Joseph Hackel

14. MOTHER'S MAIDEN NAME: Mary Bouldin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Florence Hackel | 3405 Claremont St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic cardiovascular disease | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Oak Lawn | Colgate, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-23-49 | [signature] Washington Williams, M.D. | Ulrich Funeral Home | 2008 Orleans St. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

92 D

680151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

680151 Registered No.

BIRTH NO. 48-19247

1. NAME OF DECEASED (Type or Print) MICHAEL ROSEMARY

2. DATE OF DEATH NOV. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPHS HOSP.

C. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO.
D. STREET ADDRESS (If rural, give location) 211 N. BELNORD AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | 9/7/48 | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | none | Balto. | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Urban D Rosemary | Jacqueline De Beaumont |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | NO. | HOSP. RECORDS | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) TUBERCULOUS MENINGITIS
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/7/49 19 , to 11/22/49 19 , *that I last saw the deceased alive on* 11/22 19 49 *and that death occurred at* 10 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hadden Sawinski M.D. | St. Joseph's Hosp. | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 23 | Holy Redeemer Cem | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | [illegible] for Williams, M.D. | John A. Moran | 3000 E. Balto St |

VS 150

14

correct age is especially important. Physicians, please write the cause of death in plain English—avoid abbreviations.

680152

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680152

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert Lion, Jr.

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp.

C. Length of stay in Baltimore: 12 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27
D. STREET ADDRESS (If rural, give location): 731-13 E. Lexington St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9-22-1867
9. AGE (In years last birthday): 82 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manufacturer
10B. KIND OF BUSINESS OR INDUSTRY: Swiss Embroidery

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elphan Lion
14. MOTHER'S MAIDEN NAME: Hannah Uhlfender

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mr. Albert Lion, Jr. ADDRESS: 37 S. Popplaton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
(B) Coronary arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Paget's disease, gen. arteriosclerosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9-, 1949 *to* 11-22-, 1949 *that I last saw the deceased alive on* 11-22-, 1949, *and that death occurred at* — m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert M. Farmer
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/24/49
24C. NAME OF CEMETERY OR CREMATORY: Balto. Hebrew Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

correct age is especially important. Physicians, please write the words

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680153

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Vol. 1 ✓

680153 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FOWLER, HERBERT S

2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3106 Juneau Place

D. STREET ADDRESS (If rural, give location): 3106 Juneau Place 27-01

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | March 4, 1888 | 61 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| clerk - retired | Railroad | Balto., Md. | |

13. FATHER'S NAME: George Thomas Fowler

14. MOTHER'S MAIDEN NAME: Louisa Seibold

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| none | | Mrs. Elizabeth Fowler | 3106 Juneau Pl. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | 5 weeks |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Coronary Thrombosis | 5 weeks |
| DUE TO (C) | arteriosclerotic and Hypertensive Cardiovascular Disease | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October 16, 1949, *to* Nov 21, 1949, *that I last saw the deceased alive on* Nov 21, 1949, *and that death occurred at* 9:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph H. Bird M. D. | 2818 St Paul St. Balto 18 | Nov 21, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Emerson Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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G80154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80154

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. THEODORE KISTLER

2. DATE OF DEATH: 11/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hosp.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-09
D. STREET ADDRESS (If rural, give location): 3911 Harford's Falls Pl. Bury

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED
8. DATE OF BIRTH: July 2, 1879
9. AGE (In years last birthday): 70
If Under 1 Year: Months / Days
If Under 1 Day: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mr. Henry Kistler
14. MOTHER'S MAIDEN NAME: Amelia Von Kamble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO
17. INFORMANT: Mr. Clifford Goodwin ADDRESS 2911 Gwynns Falls Pkwy

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease Yrs.
DUE TO
(B) Hypertension Years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/11 19 49 *to* 11/21 19 49 *that I last saw the deceased alive on* 11/21 19 49 *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert E. Bruce M. D.
23B. ADDRESS: Church Home Hosp.
23C. DATE SIGNED: 11/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/25/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: Wm. J. Tickner & Sons ADDRESS: Balto. Md.

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680:55

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 76 1.0

680:55 Registered No.

BIRTH NO. 49-21517

1. NAME OF DECEASED (Type or Print): Brenda Andree William

2. DATE OF DEATH: 10-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Catonsville

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Negro | N.B. | 10-5-49 | | | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Truck Driver | | Baltimore Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Osborne Granville William Jr. | Edna Irene Bell |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | Catonsville, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Palsy
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 10-5, 1949, to 10-8, 1949, that I last saw the deceased alive on 10-8, 1949, and that death occurred at ____ m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert L. Manley M.D. | Provident Hosp | 11-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL NOV 22 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Temporary for Williams, M.D. | Commissioner of Health | |

VS 150

87E

Correct age is especially important and may not be given unless the exact date of birth is known.

G80156 G80156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ARTHUR G ALDRICH

2. DATE OF DEATH 11/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST DALTO GEN HOSP

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk
D. STREET ADDRESS (If rural, give location) 11 Broadship Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W | M | Feb. 8, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Maintainance Man | Glenn L. Martin Co. | South Dakota | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edgar M. Aldrich | Viola Gilbert |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 217-01-0879 | Lynda M. Aldrich, Dundalk, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBROVASCULAR ACCIDENT

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSION

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/21/49 *to* 11/22/49 *that I last saw the deceased alive on* 11/21/49 *and that death occurred at* 2:30 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | WB GH | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 25, 1949 | Mt. Pleasant Cem. | Sioux Falls, South Dakota |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 23 1949 | Huntington Williams, M.D. | Roland L. Fisher, Dundalk, Md. |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

G80157

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. G80157 Registered No.

1. NAME OF DECEASED (Type or Print): HARRY STOWELL CATE

2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Florida
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jacksonville
D. STREET ADDRESS (If rural, give location): 2011 Broadway

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Div. | 5/23/91 | 58 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Quatermaster | Seafarer | Mass. | USA |

13. FATHER'S NAME: Wm. H. Cate

14. MOTHER'S MAIDEN NAME: Maria Proudy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ? | | 267-15-3114 | Records- US Marine Hospital | Balto, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Squamous cell carcinoma of esophagus with metastasis to abdominal lymph nodes | UNKNOWN |
| DUE TO | (B) Tuberculosis pulmonary, active | UNKNOWN |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) Trichinosis | UNKNOWN |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug 27, 1949, *to* Nov. 21, 1949, *that I last saw the deceased alive on* Nov. 21, 1949, *and that death occurred at* 8:30A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Alvin E. Cain, Surgeon M. D. | US Marine Hospital, Balto, Md. | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/22/49 | Mt. Carmel | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Lilly & Zeiler, Inc. | 403 S. Wolfe St. (31 |

46a

G80158 ✓ G80158

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 41

1. NAME OF DECEASED (Type or Print) GIMENES AUGUSTIN GINENIS

2. DATE OF DEATH 11/20/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1635 Thames Street

c. Length of stay in Baltimore Unknown (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 2-03
D. STREET ADDRESS (If rural, give location) 1635 Thames Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | UNKNOWN | UNKNOWN | 56 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant Seaman
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) UNKNOWN
12. CITIZEN OF WHAT COUNTRY? UNKNOWN

13. FATHER'S NAME UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?
(If yes, give war or dates of service) ?
16. SOCIAL SECURITY NO ?

17. INFORMANT Marine Fireman Union ADDRESS 42 South St. Balto.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial Asthma C. — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Nephritis A

DUE TO

(C) Diabetes B

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV. 17, 1949 *to* NOV. 19, 1949, *that I last saw the deceased alive on* NOV. 19, 1949, 7.30 *and that death occurred at* 8 p.m., *from the causes and on the date stated above.* NOV. 20.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry Linden M. D. | 145 Broadway Zone 31 | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/23/1949 | Mount Carmel Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1949 | Huntington Williams, M.D. | Lilly & Zeiler Inc. | Baltimore Md. |

VS 150

61

Direct age is especially important. Physician: please write the causes of death clearly and legibly.

E APPROVED BY MEDICAL EXAMINER G80139

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80139 410 Registered No.

1. NAME OF DECEASED (Type or Print): ERNEST MORRIS HIGHT

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 5311 Windsor Mill Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 4/1/97 | 52 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): NC
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm. Hight
14. MOTHER'S MAIDEN NAME: Patty Pulley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ? (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 219-10-4547
17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | 1- Congestive heart failure | Unknown |
| DUE TO | (1) Endocarditis- mitral valve probably rheumatic | |
| (B) | (2) Auriculo-ventricular heart block | Unknown |
| DUE TO | | |
| (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
R B Fisher M.D.
CHIEF OR ASST. MEDICAL EXAMINER.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DEAD ON ARRIVAL *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson
John L. Wilson, Medical Director M. D.
23B. ADDRESS: US Marine Hospital, Balto, Md.
23C. DATE SIGNED: 11/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-25-1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150

92 63

G80160

G80160

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 160

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAMIE CRAW

2. DATE OF DEATH: 23 Nov 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Waldorf B. COUNTY: Md Charles Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | My City | U.S. |

13. FATHER'S NAME: Wesley Ireland

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William A Craw | Waldorf |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the face (nos)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 15 July, 1949, *to* 23 Nov, 1949, *that I last saw the deceased alive on* 23 Nov, 1949, *and that death occurred at* 8:22 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil H. Henning Jr M. D. | 601 Winiano Way | 23 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11/23/49 | Waldorf | Waldorf Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Huntington Williams, MD | Hamilton & Ryan | Waldorf Md |

VS 150

53

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80161 G80161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 470.1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Wallace

2. DATE OF DEATH: Nov 20 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3408 Hawkins Pt Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 60 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 3408 Hawkins Pt. Rd
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 25-05
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Colored | W | Sept 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | — | White Stone Va | U.S.A. |

13. FATHER'S NAME: Samuel Wallace

14. MOTHER'S MAIDEN NAME: Marcelena

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | — | Etta Davis | 3308 Hawkins Pt Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Heart disease | |
| DUE TO | | |
| ANTECEDENT CAUSES - DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertension | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 10, 1947, *to* Nov 20, 1949 *that I last saw the deceased alive on* Nov 19, 1949 *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Rubin M. D. | 203 Belvedere Ave | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 24 1949 | Mt Calvary Cemetery | A. A. Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 23 1949 | Thurlington Williams, M.D. | Robert Williams | 1515 McElderry St |

VS 150

94a

G89162

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680162

BIRTH NO. 49-25154

1. NAME OF DECEASED (Type or Print): James A. Orr

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 3033 Liberty Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M. | W. | S. | Nov. 20, 1949 | | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Arthur L. Orr | Annie V. Whitmire |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Arthur L. Orr | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prematurity — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 46 hours

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-20, 1949 *to* 11-22, 1949, *that I last saw the deceased alive on* 6:35 PM 11-22, 1949, *and that death occurred at* 6:57 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Judith B. Lawlah M.D. | Sinai Hospital, Baltimore Md | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 25 1949 | Gillisbie Cemetery | Brevard North Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 24 1949 | Huntington Williams, M.D. | Roland L. Fisher | Dundalk, Md. |

VS 150

160a

correct age is especially important. Please write plainly. Physicians, please read the instructions on page 2 carefully before filling out this certificate.

G80163

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80163

BIRTH NO. 6

1. NAME OF DECEASED (Type or Print): Mary Bride

2. DATE OF DEATH: Nov 23-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4516 Garrison

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Stanwix Home

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Life Mos. Days

D. STREET ADDRESS (If rural, give location): 309 Dolphin St 11-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Sep-8-1859 | 90 yrs | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Balto. Md. | U.S. |

13. FATHER'S NAME: Carter Bride

14. MOTHER'S MAIDEN NAME: Mary — ? — —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Helen Hollister-Helper | 309 Dolphin St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infirmities of age — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(B) Generalized Arteriosclerosis — 20 yrs

DUE TO

(C) Arteriosclerotic Cardiovascular Renal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug, 19 49 *to* Nov, 19 49 *that I last saw the deceased alive on* Nov 22 19 49 *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Thos J Abbott M. D. | 4509 Liberty Heights | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Nov 25 | Green Mount | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 24 1949 | Registrar for Williams, M.D. | Steward Morris Co. | Balto. |

VS 150

131a

correct age is especially important. Typewriter, please.

CERTIFICATE CORRECTED 11-30-49

G8016

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 97

G8016

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Howard James Wasley

2. DATE OF DEATH 11-22-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univers. Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY PG
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bettsville Beltsville
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Oct. 26, 1942 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| child | child | Md. Prince Georges City | U.S. |

13. FATHER'S NAME Ernest W. Wasley

14. MOTHER'S MAIDEN NAME Mary Smith

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Ernest W. Wasley | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral concussion — 2 hrs.

DUE TO

(C) Chronic [illegible] nephritis — 2 yrs.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| no | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-2, 1949, to 11-22, 1949, *that I last saw the deceased alive on* 11-2, 1949, *and that death occurred at* 2:4 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | Univers. Hospital | 11-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/24/1949 | George Washington Mem. Pk. | Riverdale Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | SIGNATURE | 25. FUNERAL DIRECTOR AND ADDRESS |
|---|---|---|
| NOV 24 1949 | [illegible] for Williams, M.D. | W. W. Chambers Co - Riverdale Md. |

VS 150

1210

correct age is especially important. Physicians: please write the names of cause clearly and legibly.

G80165 ✓ G80165

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 43 V. 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martin Webber

2. DATE OF DEATH 11/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01

c. Length of stay in Baltimore Yrs. — Mos. — Days —

D. STREET ADDRESS (If rural, give location) Little sisters of Poor

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|
| male | white | single | 8/31 | 70 yrs. |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md. | |

13. FATHER'S NAME Ernardt Weber

14. MOTHER'S MAIDEN NAME Julianna Eff

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DEGENERATIVE ATHEROSCLEROTIC

DUE TO CARDIO-VASCULAR DISEASE

(B) & GRADE IV FAILURE

DUE TO

(C) PLEURAL EFFUSION RIGHT

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/22, 19 49 *to* 11/23, 19 49, *that I last saw the deceased alive on* 11/23, 19 49, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] H. Shaw M. D. | St. Agnes Hosp. | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 26/49 | Holy Redeemer | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 24 1949 | Cunningham Williams, M.D. | Rita Wiedefeld | 900 E. Biddle St |

VS 150

93D

correct age is especially important. Physicians: please write plainly and fill all blanks

680166 680166

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No. 760

STATE NO.

1. NAME OF DECEASED (Type or Print): ESTHER B. STEINBERG
2. DATE OF DEATH: 11-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2027 No Fenteelow St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2027 No Fenteelow St

c. Length of stay in Baltimore: 29 Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | ? | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Russia | |

13. FATHER'S NAME: Abe
14. MOTHER'S MAIDEN NAME: Freida

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Frank Foreman | 3802 Gorsuch Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Coronary Thrombosis | 18 hrs |
| DUE TO (B) | Arteriosclerosis | — |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Diabetes Mellitus | years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 6 1946 *to* 11-23, 1949, *that I last saw the deceased alive on* 11-23, 1949, *and that death occurred at* 6 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr Bernard Cohen, M. D. | Marlborough Apt | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-27-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 24 1949 | Hunter for Williams, M.D. | Jack Lewis Jr | 2100 Eutaw Pl |

VS 150

61

680167

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680167

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Estella Lawrence

2. DATE OF DEATH: November 21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1703 Mulliken St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
6. STREET ADDRESS (If rural, give location): 1703 Mullikin St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Colored | Married | Nov 19 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Va. | |

13. FATHER'S NAME: Jack

14. MOTHER'S MAIDEN NAME: Garfreda Holland

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Rev. L. M. Lawrence | 1703 Mulliken |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Myocarditis

DUE TO

(C) Cardio-Renal Disease

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/31, 1949 *to* 11/21, 1949, *that I last saw the deceased alive on* 11/21, 1949, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Allen L. Lafferd M.D. | 872 N. Bond St | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 24/49 | Mt Calvary Cem | A. A. County Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 24 1949 | Municipal Registrar, Md. | Mrs. Robert G. Elliott & Daughter | 1129 N. Carlton St. |

VS 150

121a

G80168

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80168

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Thomas Lee Johnson

2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jamestown
D. STREET ADDRESS (If rural, give location): 13 Orchard St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | 1-17-49 | | 10 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | New York | |

13. FATHER'S NAME: Robert Johnson

14. MOTHER'S MAIDEN NAME: Mabel Gobles

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease

DUE TO

(B) Transposition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | — | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/21, 1949 *to* 11/27, 1949, *that I last saw the deceased alive on* 11/24, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lowell Reynolds M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov-26-49 | Lakeview Cemetery | Jamestown N.Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Earl B. Houston | 403 E. 26th St. 157E |

VS 150

correct age is especially important. Physicians: please write the cause of death in plain English—avoid abbreviations

G80169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80169

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY HARRISON LEIGH

2. DATE OF DEATH: Nov. 23, 1949

3. PLACE OF DEATH: X Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W.Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weston
D. STREET ADDRESS (If rural, give location): Shadybrook

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

5c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | June 6, (?) 87[illegible] | 73 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | W.Va. | USA |

13. FATHER'S NAME: J.C. Leigh

14. MOTHER'S MAIDEN NAME: Elizabeth (?)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Chronic Myelogenous leukemia | 7 years |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | none | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | none | none |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| none m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | none |

22. *I hereby certify that I attended the deceased from* Nov. 4 1949 *to* Nov. 23, 1949 *that I last saw the deceased alive on* Nov. 23 1949, *and that death occurred at* 3:15 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Burton Hale Sr. Surg USPHS | US Marine Hospital, Balto, Md. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/25/49 | Burial | Weston West-Va |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949

REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.

25. FUNERAL DIRECTOR: Earl B Wolverton ADDRESS: 403-E-25th St. 74a

VS 150

correct age is especially important. Physician: please write clearly in ink. Use no abbreviations.

G80170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

0 57 0

Registered No. G80170

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Valerie Shane

2. DATE OF DEATH: NOV 24 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Havre DeGrace
D. STREET ADDRESS (If rural, give location): 717 Otsego St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | 7-3-48 | 1 | 16 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: James Shane

14. MOTHER'S MAIDEN NAME: Ruth Mc Fadden

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Waterhouse - Friderichsen syndrome
DUE TO
(B) Acute meningococcemia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-24 19 49 *to* 11-24 19 49 *that I last saw the deceased alive on* 11-24 19 49 *and that death occurred at* 3:45 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W. Waring M. D. | JOHNS HOPKINS HOSPITAL | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 26 1949 | Angel Hill | Havre de Grace Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | H. Madison Mitchell | Havre de Grace, Md. |

VS 150

6

correct age is especially important. Physicians: please write the name of each deceased person legibly.

680:71

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

680:71

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Samuel Weinberg

2. DATE OF DEATH: 11-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 29 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3812 Dolfield Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 16, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Own HardwareStore | Retired | Roumania | |

13. FATHER'S NAME: Sidney Weinberg

14. MOTHER'S MAIDEN NAME: Cherna

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Ray Weinberg | 3812 Dolfield Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis Myocardial Infarction — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease — DUE TO

(C) — DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-23, 1949 *to* 11-23, 1949 *that I last saw the deceased alive on* 11-23, 1949 *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Kott, M. D. | Sinai Hosp | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-25-49 | Tiferes Israel Cong. | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Emma Lee Williams, M.E. | Sol. Levinson & Bro. | 1126-26 W. North Avenue |

VS 150

937

correct age is especially important. Physicians, please write the cause of death very carefully

G80172

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80172

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rachel Adler

2. DATE OF DEATH: November 24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 816 Brooks Lane
C. Length of stay in Baltimore: 55 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 816 Brooks Lane 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1861 | 88 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Russia | |

13. FATHER'S NAME: Gerson Hordes

14. MOTHER'S MAIDEN NAME: Unkown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Rose Calmen | 816 Brooks Lane |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart Disease | 8 years |
| DUE TO (B) | Heart Decompensation | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 10, 1949 *to* Nov. 24, 1949 *that I last saw the deceased alive on* Oct 10, 1949 *and that death occurred at* 12 noon, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Sol Smith. M. D. | 1223 E. North Ave | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 25, 1949 | Beth Tfiloh Cemetery | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

correct age is especially important, physicians, please write the exact age in years

937

G80173

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80173

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Byron Ray Cummings

2. DATE OF DEATH November 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Wayne

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2214 Kensington Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9-5-91 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Executive, Engineer | | Pa. | |

13. FATHER'S NAME Byron Cummings

14. MOTHER'S MAIDEN NAME Mary Forest

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-17 1949 *to* 11-23 1949, *that I last saw the deceased alive on* 11-23 1949, *and that death occurred at* 8.30 P. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gordon Melone Carver Jr. M. D. | JOHNS HOPKINS HOSPITAL | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Greenwood Cem | Lancaster Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Chas P. Towell | 2427 Edmondson Ave. |

VS 150

46a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80:174

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 165

G80:174

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Burrell
2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1026 Washington St

c. Length of stay in Baltimore: 38 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| male | Colored | | 6-20-81 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steel Worker | | Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Booker Burrell | Margette Hallen |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | 216-10-8100 | Mrs Mary Burrell 1026 Washington St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary embolism | 12 hrs. |
| DUE TO | | |
| (B) | | |
| DUE TO | | |
| (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/21/46, 1949 *to* 11/24, 1949 *that I last saw the deceased alive on* 11/24, 1949, *and that death occurred at* 7:[illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | JOHNS HOPKINS HOSPITAL | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-27-1949 | Arbutus Memorial Pk. | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Randolph J. Callick 1532 Biddle |

VS 150

1111a

correct age is especially important. Physicians are requested to report promptly all deaths coming under their observation.

80175 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

33 ✓ G80175 Registered No.

1. NAME OF DECEASED (Type or Print): Mary C.Gier

2. DATE OF DEATH: II-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5003 St.Albans Way
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5003 St Albans Way 27-12

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: March 25th.1867
9. AGE (In years last birthday): 82 — If Under 1 Year: Months 7, Days 28; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore,Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Conrad Fuchs
14. MOTHER'S MAIDEN NAME: Mary Gunther
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. A.G.Rytina --5003 St.Albans Way — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Wks
DUE TO
(B) Arteriosclerosis
DUE TO
(C) —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: — m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?: —

22. *I hereby certify that I attended the deceased from* Nov. 1, 1949, *to* Nov. 23, 1949 *that I last saw the deceased alive on* Nov. 22, 1949; *and that death occurred at* 6 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edward Novak M. D.
23B. ADDRESS: 101 W. Read St.
23C. DATE SIGNED: Nov. 25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: II-26-49
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville,Balto:Co.Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: George J.Ruth,Inc.-1735 Harford Avenue

VS 150

correct age is especially important. Physicians: please write the cause of death plainly.

8313

680176

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680176

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BRIGID MARY McGANN — Bridget Mary McGann

2. DATE OF DEATH 11-23-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — Jenkins Memorial Hospital

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 2737 Presbury St. 15-06

| 5. SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F. | White | Single | Nov.? 1867 | 82 | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Store Keeper | Grocery | Roscomon Ireland | |

13. FATHER'S NAME: Micheal McGann

14 MOTHER'S MAIDEN NAME: Johanna Ryan

| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mary R. Russell | 2500 Ellamont St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia

DUE TO

(B) Congestive heart failure

DUE TO

(C) Arteriosclerotic CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Common duct stone & jaundice

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 25, 1949 *to* Nov. 23, 1949 *that I last saw the deceased alive on* Nov. 22, 1949, *and that death occurred at* 8:40 a. m., *from the causes and on the date stated above.*

| 23A SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Hobart J. Loucks M. D. | St. Agnes Hosp. | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 5 1949 | Huntington Williams M.D. | Chas. F. Evans & Son, Inc. | Chas. F. Evans & Son, Inc. 939 118 W. MT. ROYAL AVE. |

VS 150

correct age is especially important. Physicians: please write plainly

G80177 E976.4 G80177

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. N-853.4 Registered No.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | WALTER | WEINHARDT | 2. DATE OF DEATH: November 23, 1949 |

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 838 W. Baltimore St. 18-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (write) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | 11/25/1898 | 50 | 11 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Boiler Maker | B & O R.R. | Balto Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Chas. T. Weinhardt | Katherine Monnie |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 216-03-0073 | Mamie Sauer | Ferndale Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bullet-wound of brain | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Bowling alley | Howard St. & Druid Hill Avenue |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-22-49 ? P.m. | | Firearms |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Loudon Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams M.D. | Wm Cook Inc. | 127 St. Paul St. |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

164c

NS—432661
80178

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

19 0 Registered No. 680178

1. NAME OF DECEASED (Type or Print): Geneva Smith (Geneva Freeland Smith)

2. DATE OF DEATH: Nov. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1705 Mount St. Zone 17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | June 8, 1908 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Lombertine Freeland | Edith Bowen |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Records--Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized carcinomatosis
DUE TO
(B) Carcinoma of the breast
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1947 | Carcinoma of Breast | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-16- 1949 *to* 11-23- 1949, *that I last saw the deceased alive on* 11-23- 1949, *and that death occurred at* 12 Noon, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Regan M. D. | B. C. H.--4940 Eastern Ave. | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 26 1949 | Arbutus | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 25 1949 | Huntington Williams M.D. | Halloid Funeral Home 50 1631 Druid Hill Ave. |

VS 150

correct age is especially important. Physicians: please write the causes of death in terms of disease and not in terms of symptoms or modes of dying.

C80179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

148 Registered No.

C80179

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Rev. WILLIS JUNIUS WINSTON**

2. DATE OF DEATH **Nov. 20, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1500 Madison Ave.**
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **1500 Madison Ave.** 1402

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **Male** | **Colored** | **Married** | **Feb. 8, 1879** | **70Yrs.** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **Minister** | **Clergy** | **Ashland, Va.** | |

13. FATHER'S NAME **Phillip Winston**

14. MOTHER'S MAIDEN NAME **Ann Carter**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | **Mrs. Bertha C. Winston** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH 1500 Madison Ave.

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatous Growth Lateral wall (Left) of Pharynx — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: April 1949

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mitral Insufficiency & Moderate Hypertension

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April, 1949, *to* Nov 20, 1949 *that I last saw the deceased alive on* Nov 20, 1949, *and that death occurred at* 8:15 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph J. Young M. D. | 1429 E. Monument St | 11/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **Nov. 25, 1949** | **Mt. Calvary** | **Anne Arundel Co. Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 25 1949 | Permit for Williams, Md. | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

45F

680:80

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680:80

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry J. Lerzig

2. DATE OF DEATH Nov 22nd 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 1909 N Gay St

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1909 N Gay St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov 9th 1888 | 61 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman at Sparrows Point

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Michigan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm Lerzig

14. MOTHER'S MAIDEN NAME Jane Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-07-7157

17. INFORMANT Mrs. Lerzig ADDRESS 1030 N. Patt. Pk Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 21, 1949 *to* Nov 26, 1949 *that I last saw the deceased alive on* Nov 21, 1949 *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Conrad L. Rulon M. D. | 1706 N. Washington St | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 25th 1949 | Balto Mem | E North Ave East |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Lee & Leech | 1703 N. Patt. Pk Ave |

VS 150

94a

correct age is especially important ... Payment ... write the cause of death ...

G80:81 ✓X

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

330 Registered No. G80:81

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Fenstermann

2. DATE OF DEATH NOV 22 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto. Co.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Essex Rural Middle River
D. STREET ADDRESS (If rural, give location) Box 456 Rt. 13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1-16-92 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never B. R'road) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| B & O Railroad | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Fenstermann | Suzann Uhler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | None | Johns Hopkins Hospital | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Congenital aneurysm

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-18-, 1949 *to* 11-22-, 1949, *that I last saw the deceased alive on* 11-22-, 1949, *and that death occurred at* 12:15 a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wilham W. Winternitz M. D. | JOHNS HOPKINS HOSPITAL | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Maretzek Park Memorial | Taylor Ave, Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington for Williams, M.D. | W. J. Brzezinski | 1407 Eastern Ave |

VS 150

832a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680:82 ✓ 776 680:82

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Kavin Lloyd Drew

2. DATE OF DEATH: November 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Essex
D. STREET ADDRESS (If rural, give location): 1611 Gail Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 11/20/49 | | 3 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Raymond J. Drew
14. MOTHER'S MAIDEN NAME: Bertha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Raymond J. Drew ADDRESS: 1611 Gail Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 20, 1949 *to* November 23 1949, *that I last saw the deceased alive on* Nov. 23, 1949, *and that death occurred at* 2:00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Dwinski M. D.
23B. ADDRESS: St. Joseph's Hosp.
23C. DATE SIGNED: 11/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/25/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lillyt Zuker, Inc. ADDRESS: 4035 S. Wolfe St. (31)

VS 150

159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

80:83 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G80:83

1. NAME OF DECEASED (Type or Print) John M. Koehler

2. DATE OF DEATH Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2640 N. Charles Street
c. Length of stay in Baltimore 3 Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2640 N. Charles Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | Oct. 17, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | — | Indiana | U.S.A. |

13. FATHER'S NAME: Peter Koehler

14. MOTHER'S MAIDEN NAME: Martha Gilhoefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 333-07-7204

17. INFORMANT Union Memorial Hospital Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: immediate death

DUE TO

(B) Arteriosclerosis and Hypertensive Cardiovascular Disease — 4 plus years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 21, 1949 *to* Nov. 21, 1949, *that I last saw the deceased alive on* Oct. 7, 1949, *and that death occurred at* approx 6 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William R. Rawson M.D. | Union Memorial Hospital | Nov. 22, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Nov. 25 1949 | Glen Haven | Glen Burnie, Md. |

DATE RECEIVED NOV 25 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Thomas W. Creighton | ADDRESS Glen Burnie, Md.

VS 150

Dead on arrival at Hospital; released by medical examiner 93D

correct age is especially important. Physicians: please write the cause of death legibly

CERTIFICATE CORRECTED 11/28/49 ✓

680:34 | BALTIMORE CITY HEALTH DEPARTMENT | E816.1 | 680:34

BIRTH NO. | **CERTIFICATE OF DEATH** | Registered No.

1. NAME OF DECEASED (Type or Print) JAMES F. HALL — N-803.1 — 2. DATE OF DEATH November 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2002 Barclay Street 1-2-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Mar 3 1927 (1925) | 26 22 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Frame Maker | Children Hosp School | Washington, D C | |

13. FATHER'S NAME Howell B Hall

14. MOTHER'S MAIDEN NAME Agnes Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH**

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

(B) Intracranial hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | public | Kirk Ave. & 25th St. 9/8 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 3 A. M. November 24, 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Deceased— Auto. & Auto. Collision (passenger) |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection & Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Range M.D. | | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Final | 11/28/49 | National | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Wilson Co Inc | 1217 E Fayette St |

VS 151

170 c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80:85

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80:85

STATE NO.

1. NAME OF DECEASED (Type or Print): RAE GREEN

2. DATE OF DEATH: 11/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN HOSP

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3606 Sequoia Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Meyer Cordus
ADDRESS: 3606 Sequoia Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) CORONARY ARTERY DISEASE
DUE TO
(C) GEN. ARTERIOSCLEROSIS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/24/49 *to* 11/24/49, *that I last saw the deceased alive on* 11/24/49, *and that death occurred at* 9:15 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: W Balto
23C. DATE SIGNED: 11/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-25-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eastern Ave

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

G80:86

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80:86

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herman Ginsberg

2. DATE OF DEATH: 11-24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. 50 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13
D. STREET ADDRESS (If rural, give location): 2810 Auchentoroly Terrace

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) Years | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Jacob
14. MOTHER'S MAIDEN NAME: Mary
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Ina Ginsberg ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO:

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24, 1949, *to* 11-24, 1949 *that I last saw the deceased alive on* 11-24, 1949 *and that death occurred at* 1:45 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Aldrich Jr. M. D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 11-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-25-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

80187

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G80187
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) REUBEN CONN

2. DATE OF DEATH Nov 24/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17
D. STREET ADDRESS (If rural, give location) 2314 Bryant Ave. 13-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Yrs. √5 Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 16, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | | Russia | American |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 15 days

DUE TO

(B) Hypertensive Cardio Vascular Disease — 10 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 9, 1949, *to* Nov 24, 1949, *that I last saw the deceased alive on* Nov 24, 1949, *and that death occurred at* 8:15 H m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Frank Supplee, III M. D. | Union Memorial Hosp. | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-27-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Jack Reeves Inc | 2100 Eutaw Pl |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

680:88

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680:88

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Hoffman 501945

2. DATE OF DEATH: NOV 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Fla.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Miami Beach
D. STREET ADDRESS (If rural, give location): 2421 Lake Pancoast Drive, Apt. Helen Mar

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | 1-15- | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Russia | |

13. FATHER'S NAME: Maurice Hoffman

14. MOTHER'S MAIDEN NAME: Anna Barnard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Prostate — INTERVAL BETWEEN ONSET AND DEATH: 7 months.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Simple Fracture of the Neck of L. Femur.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June 1949 | Anaplastic Cancer involving base of Bladder | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/24/49, 19__, *to* 11/24/49, 19__, *that I last saw the deceased alive on* 11/24/49 19__, *and that death occurred at* 3.05 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | JOHNS HOPKINS HOSPITAL | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Nov 25 | Miami | Fla |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Ullman Funeral Home | 2008 Eutaw |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

516

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

~~680:89~~ BIRTH NO.

Registered No. ~~680:49~~

1. NAME OF DECEASED (Type or Print) Janice Tyra

2. DATE OF DEATH NOV 24 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Texas
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Borger
D. STREET ADDRESS (If rural, give location) 405 Butadiene St

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | | 7-20-40 | 9 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Hubert Tyra
14. MOTHER'S MAIDEN NAME Molly [illegible]
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I
(A) Brain abscess - left frontal lobe
DUE TO
(B) Pulmonary valvular stenosis, Congenital and patent foramen ovale
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 wks ?

19A. DATE OF OPERATION 11/24/49 11/23/49
19B. MAJOR FINDINGS OF OPERATION Pulmonary stenosis — Brain abscess
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-18-, 1949, to 11-24-, 1949, *that I last saw the deceased alive on* 11-24, 1949 *and that death occurred at* 7:35 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE Richard E. Griffith Jr. M.D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 11/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal
24B. DATE Nov 25 49
24C. NAME OF CEMETERY OR CREMATORY Borger Texas
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Welch Funeral Home
ADDRESS 2007 Orleans

VS 150

157E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80:90 FAUL ✓ G80:90

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John W Faul
2. DATE OF DEATH: Nov 23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: 1609 E 28th
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1609 E 28th

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Month | If under 1 Day | If under 24 Hours Hours | If under 24 Hours Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | Jun 12 1890 | 59 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | Fire Dept | Baltimore | |

13. FATHER'S NAME: Henry Faul
14. MOTHER'S MAIDEN NAME: Annie Grimel

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Norman J Faul | 3220 Belmont Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary occlusion | 5 Minutes |
| DUE TO (B) | Coronary Atherosclerosis | |
| DUE TO (C) | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* Nov 23, 1949, *that I last saw the deceased alive on* 11/21/1949 *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herman L. Warfield M.D.
23B. ADDRESS: 2900 Alameda Blvd
23C. DATE SIGNED: 11/29/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 26/49 | Loudon Park | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Ulman Funeral Home | 2008 Alameda |

VS 150

94a

BALTIMORE CITY HEALTH DEPARTMENT E 903.° G80197

# CERTIFICATE OF DEATH

Registered No. 821

BIRTH NO.

1. NAME OF DECEASED (Type or Print) 5 Stanislaus Grudowski

2. DATE OF DEATH November 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-07

c. Length of stay in Baltimore 60 Yrs. Mos. Days

D STREET ADDRESS (If rural, give location) 7400 Old Harford Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 5-6-1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Poland | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Anna Dembeck | 7400 old Harford Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, ? pulmonary

DUE TO

(B) infarction + cerebral thrombosis

DUE TO

(C) invalidism 2ndary to fracture 10 wks of hip

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

CERTIFICATION APPROVED BY

R. B. Fisher

CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (Give street address, city or town, and State. If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home - in yard | 7400 Old Harford Road |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| August 30, 1949 (Formal-am) | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Stumbled while carrying awful of wood |

22. *I hereby certify that I attended the deceased from* 11-17, 1949, *to* 11-22, 1949, *that I last saw the deceased alive on* 11-22, 1949, *and that death occurred at* 10 45 pm., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William H. Winternitz M. D. | JOHNS HOPKINS HOSPITAL | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-26-49 | St Stanislaus | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | George A. Weber | 705 S. Ann St. |

VS 150

186a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680:92 H-93105

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

H 74 680:92 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNE T. LALLY

2. DATE OF DEATH Nov. 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Caroline + Oliver Sts

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hosp

C. CITY OR TOWN Balto (If outside corporate limits, write RURAL and give township)

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2911 Hudson St. 1-41

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 11/1/47 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | None | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick J. Lally | ANNE J. Miller |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | None | Hospital records |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute laryngo-tracheo-bronchitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/21/49, 19__, *to* 11/23/49, 19__, *that I last saw the deceased alive on* 11/23/49 *and that death occurred at* 5:50 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Burnside M. D. | St. Joseph's Hosp | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Geo. R. Boyer Jr | 15 N Hollins St |

VS 150

106 c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680:93

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680:93

1. NAME OF DECEASED (Type or Print): KENNETH W. HENDERSON Sr

2. DATE OF DEATH: November 21, 1949

3. PLACE OF DEATH: Baltimore City, Maryland — Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2021 N. Fulton Avenue

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2021 N. Fulton Avenue

c. Length of stay in Baltimore: Yrs. 10 Mos. Days Yrs.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 4-1-1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Skill Laborer | Slauter House | Salem Virginia | U.S.A. |

13. FATHER'S NAME: David W Henderson

14. MOTHER'S MAIDEN NAME: Sarah A. Henderson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes War # 2 | 228-01-9324 | Mrs Clara Henderson | 2021 N. Fulton Ave |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial hypertrophy and dilatation

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER [X] / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George L. Merrill M.D. | | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-25-49 | Balto Nat. Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Elroy O. wilson | 1000 Brantly Ave. |

VS 151

92E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Lafount

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80197

80194

1. NAME OF DECEASED (Type or Print): Charles Smith Sr.

2. DATE OF DEATH: II-23-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 645 North Schroder Street

c. Length of stay in Baltimore: 7 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 645 North Schroder Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Widowed | Sept. 19, 1876 | 73 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): St Marys Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Nukoen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Charles Smith Jr. ADDRESS: 645 N. Schroder St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Myocarditis

DUE TO

(C) Cardio Renal Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 6/22, 1949 *to* 11/23, 1949 *that I last saw the deceased alive on* 11/23, 1949 *and that death occurred at* 7.00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Albert L. Lafount M. D.

23B. ADDRESS: 5221 N. Broad

23C. DATE SIGNED: 11/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: II-26-1949

24C. NAME OF CEMETERY OR CREMATORY: St Lukes Cem.

24D. LOCATION (City, town, or county) (State): St Marys Co. Md.

DATE RECEIVED BY REGISTRAR: NOV 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Elroy O. Wilson ADDRESS: 1000 Brantly Ave

VS 150

131a

Dr Janney
50:95
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 680195

1. NAME OF DECEASED (Type or Print): William Jacob Heinrich
2. DATE OF DEATH: Nov 23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3117 Rosalie Ave
C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3117 Rosalie Ave

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | Married | May 18-1867 | 82 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work, done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Plumber | Pikesville Md | |

13. FATHER'S NAME ✓
14. MOTHER'S MAIDEN NAME ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Margaret Heinrich | 3117 Rosalie |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency
DUE TO
(B) Arteriosclerotic C.V. Disease
DUE TO
(C) Prostatic Hypertrophy

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 1947, *to* Nov. 23, 1949, *that I last saw the deceased alive on* Nov 23, 1949, *and that death occurred at* 720 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathan Janney M. D. | 7101 Harford Rd. | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-26-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Registrar for Williams, M.D. | Leonard J Ruck | 5205 Harford |

VS 150

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Gordy

G80196

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80196

1. NAME OF DECEASED (Type or Print): Agnes Kate Clarkson

2. DATE OF DEATH: Nov 23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2808 Lueckert Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 2808 Lueckert Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov 12-1881 | 68 | 0 / 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Balto Md | |

13. FATHER'S NAME: Harry E Mann

14. MOTHER'S MAIDEN NAME: Carrie Stork

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Joseph Clarkson | 2801 Lueckert |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 Minute

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocarditis — 10 years

DUE TO

(C) Cholecystitis 1947

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1947 | Gall Bladder Infection Omentum Removed | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | | none |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | none |

22. I hereby certify that I attended the deceased from June 1st 1949 to Nov 25th 1949, that I last saw the deceased alive on Nov 23, 1949, and that death occurred at 11 a m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. E. Gordy MD M. D. | 5706 Sanford Rd | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-26-49 | Forest Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Lloyd J Cook | 5305 Sanford |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80:97

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

Registered No. G80:97

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carl T. Ulven ULVEN

2. DATE OF DEATH: 11/24/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1322 Walters Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 27
D. STREET ADDRESS (If rural, give location): 1322 Walters Ave 38

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Sept 1 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lady Officer | U.S.M.S. | St Paul Minn. | |

13. FATHER'S NAME: Christian Ulven

14. MOTHER'S MAIDEN NAME: Christine

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 473-16-3124 | Mrs Clara Ulven - 1322 Walters |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. L. Lubenow M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 11/24/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Balto Natural | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949

REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Leonard J Luck - 5305 Harford

94a

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80198

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80198

1. NAME OF DECEASED (Type or Print): John Joseph Madary

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3524 Glenmore Ave. 27-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | Sept 29-1904 | 45 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10B. KIND OF BUSINESS OR INDUSTRY: Northway Garage
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Geneva B Madary 3524 Glenmore

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: Nov. 23, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-25-49 | Moreland Park | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford Ave

VS 151

94a

G80:99

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4, 6

G80:99

Registered No.

1. NAME OF DECEASED (Type or Print) William Edward Engleman

2. DATE OF DEATH 11/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore Overlea
D. STREET ADDRESS (If rural, give location) 5 Chesley Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov 28 1899 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffer | Nurshing School | Union Bridge, Maryland | |

13. FATHER'S NAME: John Engleman

14. MOTHER'S MAIDEN NAME: Emma Bentzel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | ------ | 216-03-9346 | Anna Margaret Fidler | 5 Chesley Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Rheumatic cardio-vascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* November 22, 1949, *to* November 22, 1949, *that I last saw the deceased alive on* Nov. 22, 1949, *and that death occurred at* 11:15 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Madeleine Sivinski M. D. | St. Joseph's Hosp. | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 25 1949 | Parkwood Cemetery | Taylor Ave Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams M.D. | Duffel Bros. | 7110 Belair Rd |

VS 150

93 c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80200

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 053.4

G80200
Registered No.

BIRTH NO. 49-16522

1. NAME OF DECEASED (Type or Print): CAROL LEE CYR

2. DATE OF DEATH: November 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 278 Oak Grove Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | single | Aug. 10, 1949 | | 3 | 12 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilfried A. Cyr
14. MOTHER'S MAIDEN NAME: Naomi L. Bolander

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Septicemia | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: Russell S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Nov. 23, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 11-25-49 | Parkwood | Baltimore, Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: 11/25/49
REGISTRAR'S SIGNATURE: [illegible] for Williams
25. FUNERAL DIRECTOR: Lassahn Funeral Home ADDRESS: 7401 Belair Rd.

VS 15

24a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680301 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT 43

# CERTIFICATE OF DEATH

680301 Registered No.

1. NAME OF DECEASED (Type or Print): Arthur Reed

2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 601 N. Broadway

C. Length of stay in Baltimore: 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 949 Madison Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Sep. | 3-5-04 | 45 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: Bolts Copper Wks

11. BIRTHPLACE (State or foreign country): So. Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Reed

14. MOTHER'S MAIDEN NAME: Lia Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

16. SOCIAL SECURITY NO: Yes

17. INFORMANT: Edith R. Adkins ADDRESS: 949 - 7th Ave Balto. Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/28, 1949 *to* 11/21, 1949, *that I last saw the deceased alive on* 11/21, 1949 *and that death occurred at* 12:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip D. Wagley M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 11-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11/28/49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cem.

24D. LOCATION (City, town, or county) (State): Pauls Bs. S. C.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Chas. H. Corpew ADDRESS: 512 Cameron Ave

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80302 — BIRTH NO. FRANCESCO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 — Registered No. G80302

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Francesco (Frank) Provenzano

2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted]: St. Joseph's (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. App. 45 yr. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): (Baltimore) Rural - Arbutus
D. STREET ADDRESS (If rural, give location): 4421 Alan Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M. | W. | Widowed | Feb. 23, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Shoemaker-self | Italy | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| — | — |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Pete Provenzano - | Above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Arteriosclerosis, Generalized

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 23, 1949 *to* Nov. 24, 1949, *that I last saw the deceased alive on* Nov. 23, 1949, *and that death occurred at* 2:05a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kaan M. D. | 1400 N. Caroline St. | Nov. 24, 1949 |

| 24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 11/28/49 | Holy Redeemer | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Textia for Williams, M.D. | Wm. J. Tilker & Sons. | |

VS 1-58

83a

80203

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Reg. No. 4 G80203

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES BUSICK PARKER

2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 722 Newington Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 722 Newington Ave. 13-01

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 14, 1869
9. AGE (In years last birthday): 79 yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY: Dry Goods
11. BIRTHPLACE (State or foreign country): Church Creek, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Josiah Parker
14. MOTHER'S MAIDEN NAME: Virginia W. Busick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: no
17. INFORMANT: Mr. Monroe H. Martin
ADDRESS: College Park, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary arteriosclerosis 2 yrs
DUE TO
(B) Hypertension
DUE TO
(C) arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [+] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1939 *to* Nov-, 1949 *that I last saw the deceased alive on* Nov 1, 1949, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wetherbee Fort — M. D.
23B. ADDRESS: 20 E. Preston St —
23C. DATE SIGNED: 11/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/26/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Kenneth Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Baltimore, Md.

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80304

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80304

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY ELIZABETH MYERLY

2. DATE OF DEATH: Nov. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 613 E. 37th St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 613 E. 37th St. 9-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FE male | white | widow | June 25, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank D. Dietzway | Magdaline Schleupner |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. George W. Flentzie | 401 Equitable Bld |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 6 hrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Chr. arteriosclerosis | Indefinite |
| DUE TO (C) | Chr. Myocarditis | Indefinite |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb, 1936 *to* Nov 23, 1949 *that I last saw the deceased alive on* Nov 23, 1949 *and that death occurred at* 9A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathaniel M Beck M. D. | 1002 E. 23rd St Baltimore | Nov 25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680205 ✓ No. 1 680205

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Clark, Mr. Perley W.

2. DATE OF DEATH Nov. 22 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Maryland.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home For Incurables - 200 W. 40th St.

c. Length of stay in Baltimore Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Home For Incurables Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-07

D STREET ADDRESS (If rural, give location) —

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 year Months | Days | If under 24 hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | white | Widower | Nov. 9. 1877 | 72 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Baltimore, Maryland | USA |

| 13. FATHER S NAME | 14 MOTHER S MAIDEN NAME |
|---|---|
| Albert D. Clark | Sarah h. Kemp |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Charlotte Fellenbaum | Home For Incurables Records |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | 3 Hours |
| DUE TO (B) | Coronary Sclerosis | 2 years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Hemiparesis (Right) | 2 years |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 3 1949, *to* Nov. 22 1949, *that I last saw the deceased alive on* 11/23 1949, *and that death occurred at* 6.5 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Grafton Heroperger M. D. | 214 Medical Art Bldg | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 11/25/49 | Loudon Park Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS INC. | North & Pa. Aves. Balto. 17, Md. |

VS 150

94a

Correct age is especially important. Physicians: please write the cause of death very legibly.

G80206

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

20-1 G80206
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. LOUIS H. BRECHT, JR.

2. DATE OF DEATH: 11-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3140 S. Stafford street 20-06

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 8-18-1915
9. AGE (In years last birthday): 34 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10B. KIND OF BUSINESS OR INDUSTRY: Cemetery
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis H. Brecht, Sr.
14. MOTHER'S MAIDEN NAME: Mary Glick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 218-01-4654
17. INFORMANT — ADDRESS: Mrs. Alice A. Brecht 3140 Stafford St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE PULMONARY — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) EDEMA & PLEURAL EFFUSION
DUE TO
(C) BATERIAL CORONARY OCCLUSION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/22, 1949 *to* 11/23, 1949, *that I last saw the deceased alive on* 11/23, 1949, *and that death occurred at* 4:25 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Haas M.D.
23B ADDRESS: 2 E. Lexington St.
23C DATE SIGNED: 11/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/26/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: WM. J. TICKNER & SONS Balto., Md.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

G80207

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80207
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LAURA A. ARMIGER

2. DATE OF DEATH: Nov. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1907 W. Lafayette Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1907 W. Lafayette Ave. 16-34

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Feb. 10, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Louis Wilhelm | Laura Glanding |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| - | - | Mr. Wm. B. Armiger | 1907 W. Lafayette Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer Stomach — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 1 1948 *to* Nov 22 1949 *that I last saw the deceased alive on* Nov 22 1949, *and that death occurred at* 11:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. J. Mendelis M. D. | 651 N Bentalou | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Baltimore Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80-08

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

413

Registered No.

G80-08

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James D. McClain

2. DATE OF DEATH 11/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 104 So. Schroeder St.

C. Length of stay in Baltimore 24 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-03
D. STREET ADDRESS (If rural, give location) 104 So. Schroeder St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | 10/16/1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | Beckett Co. | Pennsylvania | U S A |

13. FATHER'S NAME Robert A. McClain

14. MOTHER'S MAIDEN NAME Fietta Gerais

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-09-8310

17. INFORMANT ADDRESS Mrs Lillie M. McClain

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: years

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 18, 1949 *to* Nov. 21, 1949 *that I last saw the deceased alive on* Nov. 22, 1949, *and that death occurred at* 6:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles Tommasello M. D.

23B. ADDRESS 960 W. Lombard St

23C. DATE SIGNED Nov. 25-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11/28/49

24C. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.

24D. LOCATION (City, town, or county) (State) 2930 Frederick Ave

DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J. Townsend

ADDRESS 930 Dolphin St.

VS 150

680.09

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

340.3

BIRTH NO.

Registered No. 680.09

1. NAME OF DECEASED (Type or Print) JAMES D. TOLSTON

2. DATE OF DEATH November 19, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 21 N. Calhoun Street 19-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Single | Unknown 1896 | 53 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Lunch Room | North Carolina | |

13. FATHER'S NAME Thomas Tolston

14. MOTHER'S MAIDEN NAME ? Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-05-1845

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pachymeningitis interna — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) hemorrhagica

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Generalized Arteriosclerosis

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) unknown

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) unknown

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) unknown m.

21e. INJURY OCCURRED WHILE AT [ ] NOT WHILE AT WORK [ ] unknown

21f. HOW DID INJURY OCCUR? undetermined

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23a. SIGNATURE Earl L. Kay M.D.

23b. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23c. DATE SIGNED Nov. 19, 1949

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 26, 1949

24c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery

24d. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wells Lamoreau

ADDRESS 1003 West Baltimore St.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

97

CERTIFICATE CORRECTED 11-29-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680210

680210 BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Charles O'Neill

2. DATE OF DEATH: Nov. 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-01
D. STREET ADDRESS (If rural, give location): 110 E Montgomery St

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General (00H)

3c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Sept 3, 1894 (1893) | 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor | Public Schools | Delaware | U.S.A. |

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| yes | WW #1 | |

17. INFORMANT: Mrs Vera O'Neill ADDRESS: 110 E Montgomery

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D. | | Nov. 23, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Ellendale | Ellendale, Delaware |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | John F Kenny Inc | 715 Light St |

VS 151

94a

680211

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680211

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie D. Riley

2. DATE OF DEATH: Nov 24-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3721 Northern Parkway

c. Length of stay in Baltimore Life — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-05

D. STREET ADDRESS (If rural, give location): 3721 Northern Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | April 6-1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| David Clinton | Margaret Meade |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs T. Brockman | 3721 Northern Pkwy |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis Chr. — INTERVAL BETWEEN ONSET AND DEATH: 10 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-Sclerosis

DUE TO

(C) Gangrene of left foot.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* August, 1943, *to* Nov. 22, 1949, *that I last saw the deceased alive on* Nov. 22, 1949, *and that death occurred at* 4:30 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hiram Fried M.D. M. D. | #316 Medical Arts Bldg. | Nov. 24/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-27-49 | Oak Lawn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | J. J. Hess & Son | 3001 Centre Ave |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80212 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 816.5 Registered No. C80212

1. NAME OF DECEASED (Type or Print): SHIRLEY MAE WILLIAMS — N-803.7

2. DATE OF DEATH: November 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

3c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Texas
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Houston
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | ——— | | | 6 | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ———
10B. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David
14. MOTHER'S MAIDEN NAME: Mar

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull c
DUE TO
(B) Intracranial hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Caton Ave. and Washington Blvd. Balto. Co.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-18-49 Approx. 7:15 a. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Auto. & Bus Collision

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil L. Hoyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 19 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/23/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: M. Fahey & Sons
ADDRESS: 1827 W. North Ave.

VS 151

170 c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80213 [illegible]

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

57 G80213

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Leo Vanek

2. DATE OF DEATH: 11-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 20 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 631 S. Oldham St. 26-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Nov. 11, 1904 | 45 years | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Millwright | Beth. Steel Corp. | Czechoslovakia | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Martin Vanek | unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Amelia Vanek | 631 S. Oldham St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fulminating Ulcerative Colitis
DUE TO
(B) Toxemia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-1949 | Ulcerative Large Bowel | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-23 19 *to* 11-24 19 49 *that I last saw the deceased alive on* 11-24 19 49 *and that death occurred at* 9:00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arnold Gramer M.D. | Sinai Hospital | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Holy Redeemer Cem. | 4430 Belair Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR AND ADDRESS |
|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 150

1208

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G80214

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80214

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LAURENCE CHAPMAN

2. DATE OF DEATH: November 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1415 Asquith Street 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | married | May 7, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Switchman | Pa. R. R. | Indiana | U.S. |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Emma Chapman - wife | 943 Horner's Lane |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO Coronary thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D | [X] / [ ] / [ ] | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Oak Hill Cemetery | Horner's Lane, Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 151

94a

Please write clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G80215

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80215

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Stella Ann Upton
2. DATE OF DEATH: 11-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Millersville
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | May 8, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | USA |

13. FATHER'S NAME: William Stinchcomb
14. MOTHER'S MAIDEN NAME: Ida Wheeler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT / ADDRESS: Thomas B. Upton, Millersville, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Suspected Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Diabetes Mellitus
DUE TO
(C) Early Carcinoma of Gall Bladder

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11-15-49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Gall Bladder Cholecystitis & lithiasis, Cholecysto-duodenal fistula(?)
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-3-, 1949 *to* 11-23-, 1949 *that I last saw the deceased alive on* 11-23-, 1949, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: R D Thomas Jr. M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: 11-23

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Glen Haven Mem. Park Cem. | Annapolis Blvd., Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

46F

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80216 G80216

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillian V. Causey

2. DATE OF DEATH: November 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3618 Fairview Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: none
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3618 Fairview Ave. 15-38

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | April 14, 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| artist | | Baltimore, Md. | U. S. |

13. FATHER'S NAME: William W. Causey

14. MOTHER'S MAIDEN NAME: Susie Johnston

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Eleanor C. Hadey | 3701 Garrison Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) In operable carcinoma of stomach and lungs

DUE TO

(B) Operation for primay lia ion in uterus -1939

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1939. | Carcinoma of uterus | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Aug 25, 1949, *to* Nov 24, 1949, *that I last saw the deceased alive on* Nov 14, 1949, *and that death occurred at* 4:20 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter S. Tuteur M. D. | 3220 Garrison Ave. | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Woodlawn | Woodlawn, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | John J. Mitchell & Sons, Inc. | 1901 Eutaw Pl. |

VS 150

48B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80217 — 493X — G80217

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-07156 — Registered No.

1. NAME OF DECEASED (Type or Print): BROWN, MILDRED

2. DATE OF DEATH: 11-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSP.
C. Length of stay in Baltimore: 7 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 17
D. STREET ADDRESS (If rural, give location): 1222 Gilmore St. 11-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | S | April 6, 19[illegible] | 3 Months | 17 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| child | | Balto. Md. | |

13. FATHER'S NAME: James Means

14. MOTHER'S MAIDEN NAME: Mable Cropper Brown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mable Brown | 1222 Gilmore |

## MEDICAL CERTIFICATION

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) PNEUMONIA | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | DIARRHEA, ACIDOSIS | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 9:20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Norman M. D. | Univ. Hosp. | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Mt. Auburn cem. | West Post Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams M.D. | Metropolitan Funeral Home Inc | 927 N. Mount |

VS 150

119a

G80218

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

561.0

G80218

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Carrie Louisa Gross

2. DATE OF DEATH November 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2710 Claflin Court

c. Length of stay in Baltimore 83 Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 25 - 3
D. STREET ADDRESS (If rural, give location) 2710 Claflin Court 3 r

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | C. | W. | 2-5-66 | 83 | 9 | 14 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Goldsborough

14. MOTHER'S MAIDEN NAME Frances Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Addie Dorsey ADDRESS 1805 Eagle St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction

DUE TO

(B) Incarcerated hernia Ileal inguinal.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 9, 1949, to Nov. 19, 1949, *that I last saw the deceased alive on* Nov. 18, 1949, *and that death occurred at* 8:00 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE Ronald Bofinger M.D.

23B. ADDRESS 301 Cherry Hill Road

23C. DATE SIGNED 11/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 11-25-1949

24C. NAME OF CEMETERY OR CREMATORY W.M. Zion Cem.

24D. LOCATION (City, town, or county) (State) Langdonia Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 25 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 1 S. Calvert St

VS 150

122a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80319

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80319

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorothy Williams

2. DATE OF DEATH: 11-22-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 675 Vmi St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 675 Vmi St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 675 Vmi St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | married | Feb. 6, 1924 | 25 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore | U.S.A. |

13. FATHER'S NAME: Robert Carter

14. MOTHER'S MAIDEN NAME: Mary ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | John Williams | 717 W Fayette St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 10, 1949, *to* 11/22, 1949, *that I last saw the deceased alive on* 11/21, 1949, *and that death occurred at* 9:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm Carnes M. D. | 953 Cenac St | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11-26-1949 | Mount Auburn | Cem. Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams M.D. | Wm. Patrick Williams & Sons | 329 Lafayette Ave |

VS 150

13B

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80220 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Ward 1 G80220 Registered No.

1. NAME OF DECEASED (Type or Print): Christopher Ludwig

2. DATE OF DEATH: Nov. 22/49

3. PLACE OF DEATH: Baltimore City, Maryland 821 S. Kenwood Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 821 S. Kenwood Ave.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 821 S. Kenwood Ave. 1-01

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 19, 1872
9. AGE (In years last birthday): 77 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Con. Can Co.
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John G. Ludwig
14. MOTHER'S MAIDEN NAME: Eva Gummeringer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO. 215-05-5949
17. INFORMANT: Martha Ludwig, ADDRESS: 821 S. Kenwood Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C. V. Disease — Interval between onset and death: Nov. 19/49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocarditis — Nov. 19/49

DUE TO

(C) Acute Coronary Occlusion — Nov. 22/49

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? None

22. *I hereby certify that I attended the deceased from* Nov 19, 1949, *to* Nov 22, 1949 *that I last saw the deceased alive on* Nov 22, 1949, *and that death occurred at* 6:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: E. Schmunk M. D.
23B. ADDRESS: 842 S. Esther
23C. DATE SIGNED: 11-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 26/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cem
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Lurlington Williams, M.D.
25. FUNERAL DIRECTOR: Philip Herwig Sons
ADDRESS: 2024 Orleans St.

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93D

G80221 132615

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80221

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Henry

2. DATE OF DEATH: 11-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2820 Louise Ave. 27-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Sept. 10-1877 | 72Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MD. | |

13. FATHER'S NAME: George Shaw

14. MOTHER'S MAIDEN NAME: Madeline Dickas

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | 217-01-6003 | Records B.C.H. | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-14-, 1949, *to* 11-22-, 1949, *that I last saw the deceased alive on* 11-22-1949, *and that death occurred at* 6.55 AM, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. A. Logan M. D. | B.C.H. 4940 Eastern Ave. | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 26 1949 | Holy Redeemer Cem | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Philip Henry's Sons Eastern Ave |

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80222

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80222

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE C. HICKMAN.

2. DATE OF DEATH Nov. 24-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3501-Old Frederick Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore 24 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore - Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 3501- Old Frederick Road. 20-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years, last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White. | Single. | March-28-1915. | 34 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Assembly Line. | General Motors. | Virginia | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George W. Hickman. | Myrtle T. Colson, - 3501 Old Fred'k. Ave |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes. World War No 2. | 218-09-8487 | Geo. W. Hickman, | 3501-Old Fred'k. Road. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) BRONCHOGENIC CARCINOMA | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb, 1948, *to* Nov, 1949, *that I last saw the deceased alive on* Nov. 24, 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3325 Frederick Ave | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Nov. 28-49. | London Park Cemetery. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | [signature] | Charles J. Schwab; | 3512-Fred'k. Ave. |

VS 150

47c

Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G80223

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80223

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Earnest Eades

2. DATE OF DEATH: Nov. 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01
D. STREET ADDRESS (If rural, give location): 24 Pleasant St

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 6-2-1916
9. AGE (In years last birthday): 33
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John
14. MOTHER'S MAIDEN NAME: Emma Jennings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: MARY EADES — Above
ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sickle Cell Crisis & Convulsions
DUE TO Hemorrhagic Diathesis (distress)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Sickle Cell Anemia
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
Onset 4 yrs.
Death 33 yrs.
Acute Episode for last 3 weeks

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/20 19 49, *to* 11/23, 19 49, *that I last saw the deceased alive on* 11/23, 19 49, *and that death occurred at* 11 25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Jane Cousin Wiedeman M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-27-49
24C. NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery
24D. LOCATION (City, town, or county) (State): Annapolis MD. AA MD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Dillon Reese II
ADDRESS: 108 Washington St. Annapolis, MD. AA

VS 150

720

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

680224

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420.1

680224

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Ella L. O'Conor

2. DATE OF DEATH: Nov. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5220 York Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1123 Valley Street

10-31

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | About 73 yrs | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Texas, Balto. Co. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James O'Conor

14. MOTHER'S MAIDEN NAME: Sarah Farrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS: Dr. Vincent Fitzpatrick 47 West Franklin St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Interval between onset and death: About 24 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteria Sclerosis, Hypertension — Some years.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 19 47, *to* 11/23/, 19 49, *that I last saw the deceased alive on* 11/23/, 19 49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Theodore H. Morrison M. D. | 23B. ADDRESS: 11 E Chase St | 23C. DATE SIGNED

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | St. Joseph's | Texas, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949 | REGISTRAR'S SIGNATURE: Tunstall Williams, M.D. | 25. FUNERAL DIRECTOR: H. H. Mears & Son | ADDRESS: 805 N. Calvert St.

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80225 × ✓ G80225

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ella Kucharski (Cook)

2. DATE OF DEATH Nov. 24 /49

3. PLACE OF DEATH: A. Baltimore City, Maryland N. Charles St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Doctors Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Maltimore Dundalk

D. STREET ADDRESS (If rural, give location) 1807 Homberg Ave/

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Sept 14/91 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Work | At Home | Baltimore | |

13. FATHER'S NAME J. Berdich

14. MOTHER'S MAIDEN NAME Grzesczak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT James J. Kucharski ADDRESS 1807 Homberg Av

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Arteriosclerosis

DUE TO

(C) Essential Hypertension

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/23, 1949, *to* 11/24, 1949, *that I last saw the deceased alive on* 11/24, 1949, *and that death occurred at* 7:30A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Daniel L. Zalis M. D. | 1942 Cedar Lane, 1 | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 28 /49 | St. Stanislaus | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Fred W. Ozazewski | 83a 1930 Eastern Ave |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80326 See James Description ✓ 59 ✓ G80326

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Cornish

2. DATE OF DEATH: II-2[illegible]-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 814 Little Monument St.

c. Length of stay in Baltimore: 27 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto City 10-02
D. STREET ADDRESS (If rural, give location): 814 Little Monument Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Widowed | Sept. 19. 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | In General | Va. | U.S.A. |

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| Unkown | | |

17. INFORMANT: Florence Hammond ADDRESS: 814 Little ~~Monument St~~

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Bright's Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/28, 1949 *to* 11/21, 1949 *that I last saw the deceased alive on* 11/18, 1949 *and that death occurred at* 9 P. m., *from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. B. Harkins M. D. | 4504 W. Biddle St | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | II-25-1949 | Mt Calvery Cem. | Brooklyn A.A.Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | Huntington Williams, M.D. | Elroy C. Wilson | 1000 Brantly Ave. |

VS 150

1318

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G80227
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E983.0

G80227
Registered No.

1. NAME OF DECEASED (Type or Print): Earl Cohen — N-803-7
2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 553 Mosher St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Married | August 26, 1914 | 35 | 2 | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | U.S. |

13. FATHER'S NAME: Samuel Cohen
14. MOTHER'S MAIDEN NAME: Carrie Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 211-05-5049
17. INFORMANT: Mrs Marion Cohen ADDRESS: 553 Mosher St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fracture of Skull c
DUE TO
(B) Intra cranial hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS (IF ANY) GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 453 Mosher St. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-21-49 4:30 a. m. | | Blunt force |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Nov. 21, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | November 23, 1949 | Mount Auburn Cemetery | Baltimore Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Joseph A. Lively ADDRESS: 661 West Pane St.

168

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80328

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44

G80328

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Katerine Handrejch Novak | 2. DATE OF DEATH: Nov. 22/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2038 Ashland Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland | B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-04
D. STREET ADDRESS (If rural, give location): 2038 Ashland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Feb 17 1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fruit Worker
10B. KIND OF BUSINESS OR INDUSTRY: Canning
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Handrejch
14. MOTHER'S MAIDEN NAME: Anna Hejl
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-05-9029
17. INFORMANT: Stella Novak | ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage (Apoplexy) — Interval between onset and death: 1 day
DUE TO
(B) Hypertensive Cardio Vascular Renal Disease — ?
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 10, 1949 *to* Nov 22, 1949 *that I last saw the deceased alive on* Nov 22, 1949, *and that death occurred at* 11:55 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Pokorny M. D. M. D. | 23B. ADDRESS: 2200 E Madison St | 23C. DATE SIGNED: 11/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried | 24B. DATE: Nov. 26/49 | 24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: NOV 25 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Frank Brockbal | ADDRESS: 900 Gilmore

VS 150

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

680329

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 90.0 680329 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Warfield, James — N 821.0 — 2. DATE OF DEATH 25 Nov 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital
C. Length of stay in Baltimore 1 Mon.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodbine
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 11 Mar 1858 | 91 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Maryland | U S |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John G Warfield | Ella Warthen |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes Maryland | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Broncho Pneumonia 2 days — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Fracture, Simple, complete Intertrochanteric, [redacted] of neck of femur — 1 month

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident | Home | Woodbine Maryland |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Oct 21 49 p m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Fell while undressing |

22. *I hereby certify that I attended the deceased from* 10-22 49, 19__, *to* 11-25 49, 19__, *that I last saw the deceased alive on* 11-25, 1949 *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Florence Rankin M. D. | Church Home Hosp Balto | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-1949 | Poplar Springs | Howard Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | [redacted] | C. M. Waltz | Winfield, Md |

VS 150

186a

Please write clearly and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80330

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

56.1

G80230

Registered No.

1. NAME OF DECEASED (Type or Print): Bertha Anna O'Neill

2. DATE OF DEATH: Nov. 23/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 3028 Mosher St.

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3028 Mosher St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 7, 1877
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10B. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cornelius Sowers
14. MOTHER'S MAIDEN NAME: Mary --------

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (DAUGHTER) ADDRESS: Mrs. Bertha C. Day, 3028 Mosher St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO —

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) —
DUE TO —
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: March 1949
19B. MAJOR FINDINGS OF OPERATION: Cancer of Liver
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov., 1948 *to* Nov. 23, 1949, *that I last saw the deceased alive on* Nov. 22, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Morris B. Christy M. D.
23B. ADDRESS: 543 S. Fulton Ave
23C. DATE SIGNED: 11-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 26/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): 2901 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Harry A. Lintz & Co., 4401 Edmondson Ave.

VS 150

46 F

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80231

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80231

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sallie Jane Thomas

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jones Creek, Balto., Maryland
D. STREET ADDRESS (If rural, give location): 7226 Hugh Avenue

3A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

3C. Length of stay in Baltimore: Yrs. / Mos. / Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Fe. | White | Single | Oct 3, 1946 | 3 | | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Virginia | |

13. FATHER'S NAME: Ralph Thomas

14. MOTHER'S MAIDEN NAME: Selma Estes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Ralph Thomas | 7226 Hugh Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous meningitis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 6/14/ , 1949, *to* 11/25/ , 1949 *that I last saw the deceased alive on* 11/25/ , 1949, *and that death occurred at* 3:35 PM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Suwinski M. D. | 1400 N. Caroline Street | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Oak Lawn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Lewis Torrington Williams, M.D. | Williams & Dodd | 1210 E. Fayette St |

VS 150

14

G80232

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153 Registered No. G80232

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Margaret Stultz

2. DATE OF DEATH Nov 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-08

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 4121 Frederick Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Feb. 4 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Factory Worker | Clothing | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph J Bannon | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Wilhelmina Wegenhardt | 4121 Frederick |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Generalized Carcinomatosis arising in large bowel — 2 yrs.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Debility

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 22 1949 *to* Nov. 24, 1949, *that I last saw the deceased alive on* Nov. 24 1949, *and that death occurred at* 5 15 Pm., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. Strohler M. D. | Bon Secours Hosp. | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Mt Olivet | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Herrington Williams, M.D. | Wilhelm & Son | 1217 St Paul St |

VS 150

46E

I hereby certify that the above is a correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80233

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80233

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Fredericka Strobel

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Women's Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hospital for Women of Md. - Balto. 11, Md

C. Length of stay in Baltimore: 67 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Halethorpe 27)
D. STREET ADDRESS (If rural, give location): 3718 Washington Blvd.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9-9-82
9. AGE (In years last birthday): 67 — If Under 1 Year: Months 2, Days 16 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Nat Kaaran August H. Dohrman
14. MOTHER'S MAIDEN NAME: Not known Louise Stockelyon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Earl Louis Strobel — ADDRESS: 4103 Hayward Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Aortitis, Aortic Valvular Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2+ yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Syphilis, tertiary — 7 yrs.

(C) Hypertrophic Arthritis, — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-15 1949, *to* 11-25, 1949, *that I last saw the deceased alive on* 11-24, 1949, *and that death occurred at* 2.26 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: John R. Smith, Jr. M. D.
23B. ADDRESS: Hosp. for Women, Md. Balto. 11, Md
23C. DATE SIGNED: 11-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/28/49
24C. NAME OF CEMETERY OR CREMATORY: St. Paul's Lutheran
24D. LOCATION (City, town, or county) (State): Violetsville Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Jr. — ADDRESS: 1217 St. Paul St.

VS 150

309

G80234

JAWOR

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54.3

Registered No. G80234

BIRTH NO. 49-24995

1. NAME OF DECEASED (Type or Print): Kenneth Jawor

2. DATE OF DEATH: 11/24/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN: Baltimore — 29 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 4417 Penbury Rd 28-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: 11 (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Nov. 14 1949 | | 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edward Jawor | Jean Penbury Rd |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Edward Jawor | 4417 Penbury Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease —

DUE TO

(B) patent foramen ovale —

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/23/49 *to* 11/24, 1949, *that I last saw the deceased alive on* 11/24, 1949, *and that death occurred at* 6:05 *a. m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert D. Lerskov M. D. | St. Agnes Hospital | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Holy Rosary | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Huntington Williams, M.D. | Wm Cook Inc | 1217 St. Paul St |

PLEASE WRITE PLAINLY. Use only black ink. Do not use pencil. Be sure that the information you give for items 1 to 17, with the exception of item 2, is correct as of the time of death. Be sure that the cause of death is correctly stated. Be sure that the age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1576

G80235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80235

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob B. Shearer

2. DATE OF DEATH: November 24, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 517 W. 28th Street

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 517 W. 28th Street

c. Length of stay in Baltimore: 68 years (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | June 5, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Maintenence Man | Johns Hopkins University | Maryland | U S A |

13. FATHER'S NAME: Adam Shearer

14. MOTHER'S MAIDEN NAME: Mary E. Albaugh

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Laura J. Shaffer | Hampstead, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

DUE TO

(B) Arteriosclerotic Cardio Vascular Renal

DUE TO

(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____ 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A Weiss, M. D. | 2902 Huntingdon Ave. | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 28, 1949 | Hampstead Cemetery | Hampstead, Carroll Co., Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | (Illegible) for Williams, M.D. | Burgee Funeral Home | 3631 Falls Road |

VS 150

93D

Please write plainly in ink, with pen. Do not use pencil. Please write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80236

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80236

1. NAME OF DECEASED (Type or Print): Mrs. Mary Etta Kirkley

2. DATE OF DEATH: November 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3308 Keswick Road

3c. Length of stay in Baltimore: 7 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): 3308 Keswick Road

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 24, 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Levi Pearson
14. MOTHER'S MAIDEN NAME: Urith Hayworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Sarah Basford
ADDRESS: 3315 Chestnut Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency.
DUE TO
(B) Arteriosclerotic cardiac
DUE TO
(C) disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov 19 1949 *to* Nov 23, 1949 *that I last saw the deceased alive on* Nov 22, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3429 Chestnut Ave
23C. DATE SIGNED: Nov. 25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 26, 1949
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's (Hampden)
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: NOV 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home
ADDRESS: 3631 Falls Road

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G80237

BIRTH NO. 49-25341

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80237

1. NAME OF DECEASED (Type or Print): SWIBERT

2. DATE OF DEATH: 24 Nov 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Volunteers of America Hospital
C. Length of stay in Baltimore: One (1) Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. 5
D. STREET ADDRESS (If rural, give location): 913 N Bway 5 7-04

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 24 Nov 49
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 8 / 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles Joseph Swigert
14. MOTHER'S MAIDEN NAME: Sylvania MacMagee
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT
ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) asphyxia due to ~~latent lues~~

DUE TO

(B) latent lues.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 24 Nov, 1949, to 24 Nov, 1949, *that I last saw the deceased alive on* 24 Nov, 1949, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Schulla MD M. D.
23B. ADDRESS
23C. DATE SIGNED: 24 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL NOV 25 1949
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: NOV 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS
Commissioner of Health

VS 150

1612a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80238

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80238 Registered No.

BIRTH NO. 49-25296

1. NAME OF DECEASED (Type or Print): Baby Girl Cressin

2. DATE OF DEATH: Nov. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3125 Sequoia Ave. # 15

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | S | Nov. 21, 1949 | | | 5 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Harold Cressin

14. MOTHER'S MAIDEN NAME: Elaine Freedman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Elaine Freedamn | 3125 Sequoia Ave. # |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxic anoxia — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.

DUE TO

(B) Ruptured marginal placental Sinus — 5 hrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 21, 1949 *to* Nov 21, 1949 *that I last saw the deceased alive on* Nov 21, 1949 *and that death occurred at* 10 30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irwin H. Kaiser, M.D. | | |

| 24A. BURIAL, CREMATION REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL | NOV 25 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

160c

PLEASE WRITE PLAINLY. INK ONLY. Do not use pencil. Do not fold. Do not write outside the lines. Be sure that the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80239

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80239

BIRTH NO. 49-25363

1. NAME OF DECEASED (Type or Print): Baby Thomas

2. DATE OF DEATH: November 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1204 Guantril Way

C. Length of stay in Baltimore: Yrs. / Mos. / 1 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-34
D. STREET ADDRESS (If rural, give location): 1204 Guantril Way

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If under 1 Year: Months | Days | If under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | single | Nov. 23 1949 | | | 1 | 10 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | 1204 Guantril Way, Balto. | |

13. FATHER'S NAME: Albert Guy Thomas

14. MOTHER'S MAIDEN NAME: Betty Gladys Camp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No.

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

DUE TO

(B) prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 23, 1949 *to* Nov 23, 1949 *that I last saw the deceased alive on* Nov 23 1949 *and that death occurred at* 10:45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Carol Gordon M. D. | 300 E. North Ave. | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL NOV 23 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| NOV 26 1949 | Huntington Williams, M.D. | Commissioner of Health |

VS 150

159

If birth occurred in Baltimore City, please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

G80340

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

143 Registered No.

BIRTH NO. G80340

1. NAME OF DECEASED (Type or Print): A. Elizabeth Fonty

2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1118 Hanover St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
d. STREET ADDRESS (If rural, give location): 1118 Hanover 23-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Dec 22, 1859 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Balto | U.S |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Michaels | Dont know |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | No | Miss Mary Irene Fonty | 1118 Hanover St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Auricular Fibrillation | 9 years |
| DUE TO (B) | Hypertension | 10 years |
| DUE TO (C) | Arteriosclerosis | 10 years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 15th, 1949, *to* Nov. 24, 1949, *that I last saw the deceased alive on* Nov 23rd 1949 *and that death occurred at* 4 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Hotes M. D. | 517 Scott St. | 11/25/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 26, 1949 | Balto. | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | | A. Emanuel Evans & Son | 1400 S. Charles St |

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Items must be answered in full for each case. If unknown or not applicable, write word "unknown" or "not applicable," as the case may be. Physicians: please write the causes of death clearly and legibly. Please state correct age in years, months, days, hours or minutes. Underlying cause is especially important.

G80241

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80241

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Aaron Wrightson Horney

2. DATE OF DEATH Nov. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 22-03
D. STREET ADDRESS (If rural, give location) 1721 S. Charles Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1721 S. Charles Street

c. Length of stay in Baltimore About 40 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 10, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Continental Oil Co. | Maryland | U.S.A. |

13. FATHER'S NAME Peter James Horney

14. MOTHER'S MAIDEN NAME Jennie Schrader

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | None | 213-05-6551 | Martha S. Horney | 1721 S. Charles St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Jan. , 1949 to 11/24/49 , 19__, that I last saw the deceased alive on 11/23 , 1949 and that death occurred at 3:30 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Denis Jno Gaffney M.D. | 1E Randall St. | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) / (State) |
|---|---|---|---|
| Burial | Nov. 29 1949 | Glen Haven | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | [illegible] | A. Howard Evans | 1400 S. Charles St. |

VS 150

136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as far as known. Data relating to cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

G80242

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 76 · G80242

BIRTH NO. 49-25181

1. NAME OF DECEASED (Type or Print): Baby Girl King

2. DATE OF DEATH: Nov 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto #1

c. Length of stay in Baltimore: 55 min. (Year / Month / Days)

D. STREET ADDRESS (If rural, give location): 127 N. Green St 4-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Nov 17, 1949 | | | 55 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Earl Joseph King

14. MOTHER'S MAIDEN NAME: Mildred Naomi Spicer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mother ADDRESS: 127 N. Green St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

DUE TO

(B) Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 17, 1949 *to* Nov. 17, 1949 *that I last saw the deceased alive on* Nov. 17, 1949, *and that death occurred at* 7:30 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE: Daniel Silverstein M. D.

23B. ADDRESS: West Balto Gen. Hosp

23C. DATE SIGNED: 11/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Released by Hospital R.K.

24B. DATE: 11/25/49

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: NOV 26 1949

REGISTRAR'S SIGNATURE: Huntington Williams, Jr.

25. FUNERAL DIRECTOR: ADDRESS:

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80243

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

260

Registered No. G80243

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Leslie Rumsey

2. DATE OF DEATH Nov 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 812 Park Ave

c. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 11-03

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 812 Park Ave

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widower

8. DATE OF BIRTH Feb 7 1869

9. AGE (In years last birthday) 80 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician

10B. KIND OF BUSINESS OR INDUSTRY Eye Specialist

11. BIRTHPLACE (State or foreign country) Salem N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Rumsey

14. MOTHER'S MAIDEN NAME Frances Sovereign

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Horace V. Rumsey ADDRESS 812 Park Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Coronary sclerosis and insufficieney

DUE TO

(C) Generalized arteriosclerosis
Diabetes mellitus.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/21/49, 19__, *to* 11/23/49, 19__, *that I last saw the deceased alive on* 11/23/49 19__, *and that death occurred at* 11:45 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Edward B. Ford, M. D.

23B. ADDRESS 11 E. Chase St., City-2.

23C. DATE SIGNED 11/25/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Nov 26/49

24C. NAME OF CEMETERY OR CREMATORY Druid Ridge

24D. LOCATION (City, town, or county) (State) Pikesville Md

DATE RECEIVED BY LOCAL REGISTRAR NOV 26 1949

REGISTRAR'S SIGNATURE Limited for Williams, M.D.

25. FUNERAL DIRECTOR Henry N. Jenkins Sons Co ADDRESS 49 or York Rd

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Any erasures, alterations or additions must be explained. Be sure that all items are correct and complete. Physicians: please write the cause of death clearly and legibly.

G80244

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G80244

1. NAME OF DECEASED (Type or Print): Catherine C. Tighe

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5220 York Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5220 York Rd 27-11

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: About 90 yrs
9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Campbell
14. MOTHER'S MAIDEN NAME: Catherine Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. J.F.Murray ADDRESS: 5220 York Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatous metastases to liver — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Carcinoma undetermined origin
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Senility

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 21st 1948 to Nov 25 1949 that I last saw the deceased alive on Nov 24 1949, and that death occurred at 12:26 A m., from the causes and on the date stated above.

23A. SIGNATURE: A. S. Charfoos M. D.
23B. ADDRESS: 6210 York Rd
23C. DATE SIGNED: Nov 27 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/28/49
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: H. H. Weaver and Son. ADDRESS: 805 N. Calvert St.

VS 350

55E

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item must be answered. If unknown, state so. Information should be complete and correct as space will permit. Age is especially important. Physicians: please write the cause of death clearly and legibly.

G80245

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80245

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Elsie Lillie Mitchell

2. DATE OF DEATH: Nov. 25. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 307 E. University Park

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ----------

c. Length of stay in Baltimore: 7 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 307 E. University
B. COUNTY: Balto Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 12-02
D. STREET ADDRESS (If rural, give location): 307 E. University Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Widowed | Nov 25. 1949 | 75 | 10 / 14 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | reired | Harford CO. Md. | U.S.A. |

13. FATHER'S NAME: James B. Hollis

14. MOTHER'S MAIDEN NAME: Laura V. Griffin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mary M. Benson | Pontiac Mich. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Carcinoma Lung — 8 years

DUE TO

(C) General Carcinoma Metastasis — 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1937 *to* Nov 25, 19 49 *that I last saw the deceased alive on* Nov 25, 19 49, *and that death occurred at* 4:45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert M. Foster M. D. | 2824 St Paul St | Nov 26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 28. 1949 | Baker Cemetery | Aberdeen Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Registrar for Baltimore, Md. | John O. Mitchell & Sons | 1900 Eutaw Place |

VS 150

2824 St Paul St.

46 F

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80246

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80246

STATE NO.

1. NAME OF DECEASED (Type or Print): Esther Wasserman

2. DATE OF DEATH: November 25, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2476 Shirley Ave
Mt. Carmel Home for Aged

c. Length of stay in Baltimore: 34 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 2309 Bryant Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Leon Friberg

14. MOTHER'S MAIDEN NAME: Unkown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|
| | |

17. INFORMANT: Mrs Nettie Kessler — ADDRESS: 2309 Bryant Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Bronchopneumonia | 12 hours |
| DUE TO | | |
| (B) | Arteriosclerotic Heart disease with Auricular Fibrillation | ? |
| DUE TO | | |
| (C) | Cerebral Arteriosclerosis | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 25, 1949 *to* Nov 25, 1949 *that I last saw the deceased alive on* Nov 25, 1949 *and that death occurred at* 2:15 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis V. Blum M. D. | 2310 Eutaw pl. | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 27, 1949 | Baltimore Hebrew Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | | Sol Levinson & Bros | 1126 W North Ave |

VS 150

93D

PLEASE WRITE PLAINLY WITH UNFADING INK. Any information omitted should be secured if possible. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G80247

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80247

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary Davis

2. DATE OF DEATH Nov. 24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01

D. STREET ADDRESS (If rural, give location) 1200 Valley St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | W. | Sept. 12, 1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME James McCarthy

14. MOTHER'S MAIDEN NAME Mary Helling

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Lillie Dykeman ADDRESS 1200 Valley St |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocarditis — 2 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 1 1949, *to* Nov 24 1949, *that I last saw the deceased alive on* Nov 23 1949, *and that death occurred at* 6:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Gill Hall M. D. | 1631 E. North Ave | Nov 26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 28/49 | St Johns | Ellicott City Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 26 1949 | [illegible] Williams, M.D. | Rita Wiedefeld 900 E. Biddle St |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

C80248
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Vol. 1 C80248
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): George T. Brown
2. DATE OF DEATH: 11/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 102 S. Gilmor St.
C. Length of stay in Baltimore: 5 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 102 S. Gilmor 19-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Dec. 19, 1868 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Washington D.C. | |

13. FATHER'S NAME: Thomas Brown
14. MOTHER'S MAIDEN NAME: Anna Solbach

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Emma Hamilton, ADDRESS: 2562 W. Fairmount Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic H-V Disease | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| C. P. Lubinski M.D. | | 11/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 26/49 | London Pk. 3801 Frederick Rd. Balto. Md. | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Registrar for Baltimore, Md. | Harry H. Nitzke | 4101 Edmondson Ave. |

VS 151

93D

CERTIFICATE CORRECTED 1-5-50

G80249

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E812.4 G80349

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES L. TYLS N-804.

2. DATE OF DEATH Nov. 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospital

c. Length of stay in Baltimore 45 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore-20 Rural Middle River
D. STREET ADDRESS (If rural, give location) 5 Yawmeter Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Czechslovakia | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| – | None | Edith M. Austin - Above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Fractured lumbar vertebra

(C) Traumatic amputation, right leg

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | public | Martin Blvd. & Compass Rd., Balto.Co. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-9-23-49 7:39 p. m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Pedestrian struck by auto. |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Paul L. Kaye M.D. | | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/26/49 | Oak Hill Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | [illegible] | John G. Connelly- | Essex, Md. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

170 C

G80350 ✓ E81-4 G80350

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HATTIE CARTER — N-828.4

2. DATE OF DEATH November 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-02
D. STREET ADDRESS (If rural, give location) 607 W. Sarahanne Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | unk. | 6-1-1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Martin Carter | Isabelle ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Theresa Carter | 607 Sarah Ann St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Pelvis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Fracture of Rt. tibia + fibula

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Mitral + Aortic Stenosis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | street | Wilkens and Primrose Aves. 25/41 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| November 22, 49 5.30 p.m. | WHILE AT WORK [ ] NOT WHILE AT WORK [x] | pedestrian struct by an automobile |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | Nov. 23, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11-28-1949 | Mt Auburn Cem | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams Services | 322 N |

VS 151

1701c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80331

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. G80331

1. NAME OF DECEASED (Type or Print): Henrietta Johnson

2. DATE OF DEATH: Nov. 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-02
D. STREET ADDRESS (If rural, give location): 1327 Argyle Ave. Zone 17

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Yrs. life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Negro | Widowed | Feb. 7, 1876 ? | 73? (70)? | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: Deceased

14. MOTHER'S MAIDEN NAME: Deceased

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriolar nephrosclerosis
DUE TO
(C) Hypertensive Cardiovascular disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 11-20-, 1949, *to* 11-23-, 1949, *that I last saw the deceased alive on* 11-23-, 1949, *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rogers M. D. | B.C.H.--4940 Eastern Ave. | 11-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-26-1949 | W. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 322 N Schroeder St |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

121a

G80252

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

445 Registered No.

G80252

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) BALLENTINE, OTHA T.

2. DATE OF DEATH 11/24

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Bal. Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ball. md. 18-62
D. STREET ADDRESS (If rural, give location) 1027 Edmonson

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Married | 11/4/19 | 30 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Presser | | N.C. | U.S.A |

13. FATHER'S NAME Melvin L Ballentine
14. MOTHER'S MAIDEN NAME Sophronia Fuller

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT Sophronia Ballentine ADDRESS 1027 Edmondson ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Renal Failure
DUE TO
(B) Malignant Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/14, 19 49 P *to* 11/24, 19 49, *that I last saw the deceased alive on* 11/23, 19 49 *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Holmes M. D. | Provident Hosp | 11/24 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 11-26-1949 | Angels L.C. | Angels N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Funeraltion Williams, Md | Mrs Katie R Williams | 522 N Schroeder St. |

VS 150

102

G80253

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80253

BIRTH NO.

1. NAME OF DECEASED (Type or Print): C. Albert Sakell

2. DATE OF DEATH: Nov. 23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2019 Wilhelm St.

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-0-02
D. STREET ADDRESS (If rural, give location): 2019 Wilhelm St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Dec-12-1883 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Meiser Iron Worker | Helper. | Baltimore. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frederick Schell | Wilhelmina Schmidt. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 217-07-3252 R. | August Schell | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary insufficiency | 3 mons |
| DUE TO (B) | [redacted] | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/29, 1949 *to* 11/23, 1949, *that I last saw the deceased alive on* 11/23, 1949 *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Miller M. D. | 2230 Wilkens ave | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 26/49 | Western Cemetery | Pikesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 25 1949 | [illegible] | F. B. Wright & Son | 1200 Eutaw Pl. - 17 |

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80254

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E97-0 G80254 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Lee Willis Wright — N-968.0

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 725 E. Coldspring Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Mar. 13, 1911 | 38 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | Taxi Cab | Md. | |

13. FATHER'S NAME: R. Willis Wright

14. MOTHER'S MAIDEN NAME: Blanche Michael

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | none | | Mrs. Annette Wright | 725 E. Cold SpringLa |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO
(B) illuminating gas
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 725 E. Colespring Lane |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 25, 1949 A m. | | Illuminating gas All burners on stove on but unlit |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | Nov. 25, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/29/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | [illegible] | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

163H

CERTIFICATE CORRECTED 12-1-49

G80255

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80255

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPHINE ~~ANNE~~ HUSS

2. DATE OF DEATH 11-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hosp. for the Women of Maryland

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-02
D. STREET ADDRESS (If rural, give location) 3410 University Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Widowed | June 3, 1866 | 83 | 5 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Hotel | — | New York, N.Y. | U.S.A. |

13. FATHER'S NAME Andrew Lauder

14. MOTHER'S MAIDEN NAME Anna Swartz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Patient | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | |
| DUE TO | Coronary arteriosclerotic & Exclusive disease | |
| ANTECEDENT CAUSES (B) | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Congestive Heart Failure | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-21, 1949 *to* 11-25, 1949 *that I last saw the deceased alive on* 11-25, 1949, *and that death occurred at* 8:25 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. P. Benson, Jr. M. D. | Womens' Hosp. | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Evergreen Cem. | Brooklyn, N. Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 26 1949 | [illegible] for Williams, M.D. | WM. J. TICKNER & SONS, Baltimore, Maryland |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

94a

G80256
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 2 1. 4

G80256
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) William Morgan

2. DATE OF DEATH 11/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 627 Archer St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 627 Archer St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) — 21-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Col | — | July | 65 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | N. C | |

13. FATHER'S NAME James Morgan

14. MOTHER'S MAIDEN NAME Mary Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Maud Dixon | 627 Archer St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Valvular Heart Disease — Interval between onset and death: Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B) Arteriosclerosis — Interval: "

DUE TO (C) Senility — Interval: "

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-2, 1949 *to* 11-23, 1949, *that I last saw the deceased alive on* 11-27, 1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles T. Woodall M. D. | 821 Hamilton | 11-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/26/49 | Scotland N. C | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | [illegible] Williams M.D. | Isaiah L Brown Sr | 1081/2 Montgomery St |

VS 150

927

G80257

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

0 2 4

Registered No. G80357

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth B. Benson

2. DATE OF DEATH: Nov. 24th. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2613 Huntington Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2613 Huntington Ave.

c. Length of stay in Baltimore: 64 Years (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Mch. 6, 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Housekeeper | At Home | Baltimore, Md | |

13. FATHER'S NAME: William H. Benson

14. MOTHER'S MAIDEN NAME: Florida Hartley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Mr. Wm. E. Benson | 2613 Huntington Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Syphilis | 12 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Tabes Dorsalis | 8 yrs. |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cardio-renal-vascular Disease | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 9 1937 *to* Nov. 24, 1949, *that I last saw the deceased alive on* Nov. 24, 1949, *and that death occurred at* 9:40P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. H. Wilson M. D. | 617 W. 40th St. | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Druid Ridge Cemetery | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 26 1949 | Huntington Williams, M.D. | Geo. L. Berger Jr. | 1512 Hollins St. |

VS 150

30a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80358 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G80358

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOWE, HOWARD
2. DATE OF DEATH: 11/26/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.
c. Length of stay in Baltimore: 5 yrs.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 489 Edgewater Apts.
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar. 10, 1905
9. AGE (In years last birthday): 44 yrs.
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Operator
10B. KIND OF BUSINESS OR INDUSTRY: Steel Co.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James T. Lowe
14. MOTHER'S MAIDEN NAME: Mary F. Rawls
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 244-07-6041
17. INFORMANT: Mr. Albert Slagle ADDRESS: 1128 H St., Sparrows Pt., Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Toxemia

DUE TO

(B) Uremia

DUE TO

(C) Carcinoma of Pancreas

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV. 15, 1949, *to* NOV. 26, 1949, *that I last saw the deceased alive on* 11/26, 1949, *and that death occurred at* 5:40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. Leonard Dasser M.D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 11/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 11/26/49
24C. NAME OF CEMETERY OR CREMATORY
24D. LOCATION (City, town, or county) (State): Petersburg, Va.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 27 1949
REGISTRAR'S SIGNATURE: Emily Lee Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80259 ✓ 50.0 G80259

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): ELIZABETH BOOTH FARINHOLT

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4303 Maine Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-02
D. STREET ADDRESS (If rural, give location): 4303 Maine Ave.

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Nov. 15, 1855
9. AGE (In years last birthday): 94 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: - Hundley
14. MOTHER'S MAIDEN NAME: Sophronia Dyke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mr. L. W. Farinholt, Jr. ADDRESS: 109 Woodlawn Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arterio-scleroses — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1/49, 19__, *to* Nov. 26, 1949, *that I last saw the deceased alive on* Nov. 25, 1949, *and that death occurred at* 5:4 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wallace Gilbett M. D.
23B. ADDRESS: 2220 Harrison Blvd
23C. DATE SIGNED: Nov. 26 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/28/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 27 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

107

G80660

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 G80260

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): WALTER EDGAR WINDSOR

2. DATE OF DEATH: Nov. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): the Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 2641 Guilford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 18,1880 | 69 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Installation Dept. | Telephone Co. | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Glendy S. Windsor | Mary V. Codd |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Anna K. Windsor | 2641 Guilford Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Embolus | 10 min. |
| DUE TO (B) | Hypertensive Cardio-Vascular Disease with Fibrillation. | — |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November 4, 1949, *to* November 25, 1949, *that I last saw the deceased alive on* November 25 1949, *and that death occurred at* 1:20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Newland Edward Day M. D. | 4-E-33rd St-18 | Nov. 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Loudon Park Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | Deputy for Marianna, Md | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

931

G80261

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 80261

BIRTH NO. 49-16258

1. NAME OF DECEASED (Type or Print): Baby Margaret Rose Sutton

2. DATE OF DEATH: 11/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes

c. Length of stay in Baltimore: 3 ~~Yrs.~~ Mos. ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 1420 Dukeland Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | 8/6/49 | | 3 | 19 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles V. Sutton Jr.
14. MOTHER'S MAIDEN NAME: Jeanette M. White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGENITAL HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) BILATERAL PNEUMONIA
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [4] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/13, 19[illegible] *to* 11/26, 19[illegible] *that I last saw the deceased alive on* 11/26, 19[illegible], *and that death occurred at* 12:5[illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: John H. Shaw M. D.
23B. ADDRESS: 1[illegible] Cathedral St.
23C. DATE SIGNED: 11/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/28/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: acting for Milliam, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80362 ✓ 334 G80262

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Wallace

2. DATE OF DEATH: Nov. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 126 W. 22nd st

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ✓
8. DATE OF BIRTH: 3-18-07
9. AGE (In years last birthday): 42 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Calvert Co Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Freeland
14. MOTHER'S MAIDEN NAME: Mamie Chew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Louis Wallace — ADDRESS: 2001 Wetheredville Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Essential hypertension, malignant | |
| DUE TO | hypertensive encephalopathy | |
| (B) | nephritis and uremia | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/20 19 49 *to* 11/25 19 49, *that I last saw the deceased alive on* 11/25 19 49, *and that death occurred at* 12 00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: William W. Winternitz M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 11-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 29-1949
24C. NAME OF CEMETERY OR CREMATORY: Patexent Huntington Md
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: NOV 27 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: P.E. Swell — ADDRESS: Prince Fredrick Md.

VS 150

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680263

BIRTH NO 49-22713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): PATRICIA NORRIS

2. DATE OF DEATH: 11-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
c. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sparks
D. STREET ADDRESS (If rural, give location): Rt 2

5. SEX: F. | 6. COLOR OR RACE: C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single | 8. DATE OF BIRTH: Oct 20 1949 | 9. AGE (In years last birthday): If Under 1 Year Months 1 Days 5 | If Under 24 Hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: William Crowder
14. MOTHER'S MAIDEN NAME: Louise Whyte

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mother ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 11-22
DUE TO
(B) Dehydration — 11-26
DUE TO
(C) Diarrhea

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 22, 1949, *to* Nov. 26, 1949, *that I last saw the deceased alive on* Nov. 26, 1949, *and that death occurred at* 4:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Edwin M. Hubbard M. D. | 23B. ADDRESS: Univ. Hosp. | 23C. DATE SIGNED: 11-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 11-27-49 | 24C. NAME OF CEMETERY OR CREMATORY: St. Lukes | 24D. LOCATION (City, town, or county) (State): Monkton, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 27 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR: Landon M. Brooks, Sparks, Md. | ADDRESS

VS 150

119a

G80264 G80264

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

48 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): William Burkley Vane

2. DATE OF DEATH: Nov.24,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 337 Warren Ave.,

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-02
D. STREET ADDRESS (If rural, give location): 337 Warren Ave.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct.8,1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Ship Builder | | Md. | |

13. FATHER'S NAME: William Vane

14. MOTHER'S MAIDEN NAME: Sarah Patterson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | none | Mrs. Eva E. Vane 337 Warren Ave., |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) DUE TO | Broncho-pneumonia following influenza. | 13 days |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | Hypertensive cardio vascular disease. | ? |
| | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 12, 1949 *to* 11/24/, 1949 *that I last saw the deceased alive on* 11/24/49 19___, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1226 Hanover Street, | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Loudon Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 28 1949 | [signature] | G. Howard Strong 3207 W. North Ave., |

VS 150

937

G80365

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

334 Registered No. G80365

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): John F. Lins

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2518 Arunah Ave.,

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 2518 Arunah Ave.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 9, 1868 | 81 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10B. KIND OF BUSINESS OR INDUSTRY: Record & Goldsborough
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Jacob Lins
14. MOTHER'S MAIDEN NAME: Louise Linz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Isabel D. Lins ADDRESS: 2518 Arunah Ave.,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Apoplexy.
DUE TO
(B) Senility and Arterio-Sclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Sept 1949 *to* Nov 25, 1949 *that I last saw the deceased alive on* Nov 25, 1949, *and that death occurred at* 12:55 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3033 W North Ave
23C. DATE SIGNED: 11-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-28-49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 27 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: G. Howard Strong ADDRESS: 3207 W. North Ave.,

VS 150

83a

G80366

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G80646

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Joseph Klein

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 23-01
D. STREET ADDRESS (If rural, give location): 912 S. Charles St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | — | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10B. KIND OF BUSINESS OR INDUSTRY: Furniture

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham

14. MOTHER'S MAIDEN NAME: Goldie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Harry Klein (son) ADDRESS: 912 S Charles St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 48 hr.?

DUE TO

(B) arteriosclerotic C-V-D. — 20 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 11-23, 1949 *to* 11-25, 1949 *that I last saw the deceased alive on* 11-25, 1949 *and that death occurred at* 11 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Burton V. Lochner M.D. | Mercy Hosp. | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 11-27-49 | Hebrew Herrmon Mem | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | Signature for Registrar, M.D. | Jack Reevos Inc | 2100 Eutaw Pl |

VS 150

937

G80367

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

754.5

G80367 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. NAME OF DECEASED (Type or Print) MORRIS J. FELD

2. DATE OF DEATH November 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2700 Classen Avenue

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13
D. STREET ADDRESS (If rural, give location) 2700 Classen Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | | 23 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Nathan
14. MOTHER'S MAIDEN NAME Yetta
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Jean Feld ADDRESS 2700 Classen Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Congenital heart disease (coarctation of aorta)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED Nov. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 11-27-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Run
24D. LOCATION (City, town, or county) (State) Balto Md
25. FUNERAL DIRECTOR ADDRESS Jack Lewis Inc 2100 Eutaw Pl

DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1949
REGISTRAR'S SIGNATURE Thomas J. Williams

VS 151

157E

G80368 : G80368

G80368 BALTIMORE CITY HEALTH DEPARTMENT 443 Registered No.

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LENA EHRLICH

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1701 Ellamont St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Feinblatt's Nursing Home

c. Length of stay in Baltimore: 40-41 Yrs. 12-04 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND — B. COUNTY: None
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2344 BARCLAY ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | White | | FEB 12, 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Poland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Milton Miller | [redacted] ESTHER MILLER |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | NO | | SIMON EHRLICH | 2344 Barclay |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Pneumonia, Terminal | 2 days. |
| DUE TO | | |
| (B) | Cerebral Hemorrhage | 2½ days. |
| DUE TO | | |
| (C) | Hypertensive Cardio-vascular Disease, with Auricular Fibrillation. | 10 years |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* February 19 49 *to* Nov. 26, 1949 *that I last saw the deceased alive on* 11-26, 1949 *and that death occurred at* 11 20 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. M. Miller M. D. | 1613 E. Baltimore St. | 11-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
|---|---|---|---|---|
| Burial | 11-27-49 | Rosedale | Balto | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | Inactive for Baltimore, Md. | Jack Lewis Inc | 2100 Eutaw Pl |

VS-150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80369 BALTIMORE CITY HEALTH DEPARTMENT Dr. No. 1 G80369

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KATHERINE AIKEN

2. DATE OF DEATH Nov. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2906 W. Cold Spring Lane
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-13
D. STREET ADDRESS (If rural, give location) 2906 Cold Spring Lane, West

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | About 1879 | About 70 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | At Home | Baltimore, Md. | |

13. FATHER'S NAME George B. Aiken

14. MOTHER'S MAIDEN NAME Mary Wolveryon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Robert F. Barrett | 2804 Overland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Generalized Arterio Sclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT? SUICIDE. HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 25, 1949 *to* Nov 26, 1949, *that I last saw the deceased alive on* Nov 26, 1949 *and that death occurred at* 2:45 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John D Barrett | 4803 Eastern Ave. Highlandtown | Nov 26 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | Timothy Joe Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the causes of death clearly and legibly.

VS 180

920

G80370

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

47-1

G80270

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CELIA MEYER

2. DATE OF DEATH: 11-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4613 Park Heights Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Sinai Home

C. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 4115 Chatham Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Jacob

14. MOTHER'S MAIDEN NAME: Hannah

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Simon Meyer | 4115 Chatham Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardiac Infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis, generalized — —

DUE TO

(C) Acute Cardiac Dilatation — 48 hours

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-24, 1949, *to* 11-26, 1949, *that I last saw the deceased alive on* 11-26, 1949, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| David J Schwartz M. D. | 2320 Eutaw Place | 11/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 11-27-49 | Hebrew Herring Run | Balto | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | Evangeline Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80371

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450 G80371

BIRTH NO. G80371 Registered No.

1. NAME OF DECEASED (Type or Print) SILAS ADAMS BARNS

2. DATE OF DEATH November 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 4-02
D. STREET ADDRESS (If rural, give location) 732 W. Lexington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | MARRIED | August 12, 1874 | 75 76 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10B. KIND OF BUSINESS OR INDUSTRY CARPENTER
11. BIRTHPLACE (State or foreign country) CARROLL COUNTY, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES BARNES
14. MOTHER'S MAIDEN NAME ELIZA FRIZEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerosis | |
| | DUE TO (B) | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 9-24-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-29-49 | MT. OLIVET CEMETERY | HANOVER, PA. |

DATE RECEIVED BY LOCAL REGISTRAR NOV 27 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR WM. J. TICKNER & SONS ADDRESS BALTO, MD.

VS 151

97

Dr Harding

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80272

Registered No. G80272

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William John Sholl

2. DATE OF DEATH: Nov 25-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4803 Mannasota

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-12
D. STREET ADDRESS (If rural, give location): 4803 Mannasota Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb-21-1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Penna. | |

13. FATHER'S NAME ✓

14. MOTHER'S MAIDEN NAME ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Julia Sholl ADDRESS: 4803 Mannasota

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ch. Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 years.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ch. Nephritis

DUE TO

Arteriosclerosis

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| ✓ | ✓ | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| ✓ | ✓ | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| ✓ | ✓ | — |

22. *I hereby certify that I attended the deceased from* May 48, *to* Nov 25, 1949, *that I last saw the deceased alive on* Nov 24, 1949, *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| JS Harding M. D. | 3805 Belair Rd | Nov 26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Maryland Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | | Lemuel J Luck - 5305 | Harford Rd. |

VS 150

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G80273 CERTIFICATE CORRECTED 1-3-50 G80273

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) DOUGLAS H. MATTERSON E812.4 N-8-4-1 | 2. DATE OF DEATH November 24, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital<br>c. Length of stay in Baltimore Yrs. Mos. Days | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson<br>D. STREET ADDRESS (If rural, give location) Northwind Road |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 24, 1894 | 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Iron Worker | Md. Steel Products | Baltimore, Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ✓ | ✓ |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Myrtle Matterson, North Wind Rd. |

MEDICAL CERTIFICATION

| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | |
| | DUE TO | |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchopneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public | Bush & ~~Russell~~ Ridgely Streets 21/2 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 4:05p November 21, 1949 m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Pedestrian ran into auto, in motion |

22. *I certify that I took charge of the remains described above, held an* Autopsy & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection & Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Nov. 25, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Parkwood | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 27 1949 | Huntington Williams, M.D. | Leonard J. Mulik, 5305 Harford Rd. ✓ |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

176 c

Dr. M. Kress
Med. arts Bldg

G80374

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80374

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Clara M. Loeffler

2. DATE OF DEATH: Nov. 25-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3301 Lawnview Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-03
D. STREET ADDRESS (If rural, give location): 3301 Lawnview Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Aug 15-1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Baltimore Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Theodore Groslop | Mary |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs John H. Loeffler | 3301 Lawnview |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Feb 48 to Nov 25, 1949, *that I last saw the deceased alive on* Nov 25, 1949, *and that death occurred at* 11.35 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton B. Kress M. D. | Med arts Bldg | 11/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | | Leonard J. Luck | 5305 Harford Rd. |

VS 150

13B

G80275

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 491 G80275

BIRTH NO. 48-12366

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): LINDA PORTER

2. DATE OF DEATH: 11/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH'S HOSP.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Middle Rivers
D. STREET ADDRESS (If rural, give location): 123 Selfridge

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | June 12, 1948 | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Balto., Md. | |

13. FATHER'S NAME: Charles W. Porter, Jr.

14. MOTHER'S MAIDEN NAME: Elizabeth R. Snyder

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | -- | -- |

17. INFORMANT: Hospital Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumonia, bronchial
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/25/49 *to* 11/25/49, *that I last saw the deceased alive on* 11/25, 1949, *and that death occurred at* 11:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Swinski M. D. | St. Joseph's Hosp. | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Nov. 29, 1949 | St. Josephs | Fullerton, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 27 1949 | Hunting for Nicholas | Lansdale Funeral Home | 7401 Belair Rd. |

VS 150

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G80376

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80376

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARVARD EASTWOOD

2. DATE OF DEATH November 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Johns Hopkins Hospital

C. Length of stay in Baltimore — Yrs. / Mos. / Days: Life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-07
D. STREET ADDRESS (If rural, give location): 1224 N. Gay Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | white | Widowed | July 1886 | 63 | 4 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Huckster | | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Walter Eastwood

14. MOTHER'S MAIDEN NAME: Laura Magness

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Mr. George Eastwood | 1224 N. Gay Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic cardiovascular disease | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Nov. 25, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | II-28-49 | Baltimore Cemetery | East North Avenue, Balto: Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 27 1949 | Pending for Autopsy Rpt | George J. Ruth, Inc. - 1735 Harford Avenue |

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93 ✓

ES-12803 G80277 ✓ G80277

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 49-0

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Harry Washington Campbell

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md; B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1713 W. LOMBARD STREET. 19-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Wid. | Feb. 2, 1878 | 71 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Augusta (august) Campbell

14. MOTHER'S MAIDEN NAME: Fannie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: RECORDS* BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC HEART DISEASE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-5- , 19 49 , *to* 11-25 , 1949 , *that I last saw the deceased alive on* 11-25 1949 , *and that death occurred at* 12:15 m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Rogers M. D.

23B. ADDRESS: 4940 EASTERN AVENUE

23C. DATE SIGNED: 11-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: NOV. 28 1949

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem

24D. LOCATION (City, town, or county) (State): Frederick Av

DATE RECEIVED BY LOCAL REGISTRAR: NOV 27 1949

REGISTRAR'S SIGNATURE: Funeral Director Williams, M.D.

25. FUNERAL DIRECTOR: Thos. J. Kenny-Inc. ADDRESS: 1600 Hollins St

93D

G80278 E 902.0 G80278

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Florence May Wedge. N-8

2. DATE OF DEATH: Nov. 25 /49

3. PLACE OF DEATH: A. Baltimore City, Maryland 5631 Reisterstown Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-19
D. STREET ADDRESS (If rural, give location): 5631 Reisterstown Road

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | W. | May 3, 1857 | 92 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Mc Clure

14. MOTHER'S MAIDEN NAME: Elizabeth Bain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —

(If yes, give war or dates of service) —

16. SOCIAL SECURITY NO —

17. INFORMANT: Mr. Russell M. Wedge Jr. ADDRESS: 5631 Reisterstown Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: July 5. 1949

DUE TO

(B) Arterio Sclerosis — ?

DUE TO

(C) Fractured hip — Oct-5. 1949

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY: Earl Koons

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (Give exact location): 5631 Reistertown Rd.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Oct. 5, 1949 A m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fell to bedroom floor (getting out of bed)

22. *I hereby certify that I attended the deceased from* July 5 , 19 49 , to Nov 25 , 19 49 *that I last saw the deceased alive on* Nov 25 , 19 49 *and that death occurred at* 7.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louis D Bebert M. D. | 23B. ADDRESS: 4803 Park Heights Ave | 23C. DATE SIGNED: Nov 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Nov 28/49 | 24C. NAME OF CEMETERY OR CREMATORY: London Park | 24D. LOCATION (City, town, or county) (State): Baltimore, Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949 | REGISTRAR'S SIGNATURE: [illegible] Walter Williams, M.D. | 25. FUNERAL DIRECTOR: Loring Byers | ADDRESS: 5005 Pk Heights Ave

VS 150

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80279

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0 Registered No. G80279

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Catherine McLaughlin

2. DATE OF DEATH: Nov. 27, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE W. Va
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Berkeley Springs
D. STREET ADDRESS (If rural, give location) Box 285

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 4-13-2[illegible] | 2[illegible] | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Bon Sample Manors Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles W Carlslie
14. MOTHER'S MAIDEN NAME: Bertha E Knuglit
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Chas W. Carlslie, ADDRESS: Berkeley Springs

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro intestinal hemorrhage — Interval between onset and death: 1 day
DUE TO
(B) Esophageal varices — 1 yr
DUE TO
(C) Portal cirrhosis and portal hypertension — 10 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Nov. 18, 1949.
19B. MAJOR FINDINGS OF OPERATION (Splenorenal anastomosis): Ascites - Cirrhosis of liver - Splenomegaly
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): none
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: None
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from 11-1-49 to 11-27-49 that I last saw the deceased alive on 11/27/49 and that death occurred at 2 [illegible] m., from the causes and on the date stated above.

23A. SIGNATURE: Duane L Merrill M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 11/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-30-49
24C. NAME OF CEMETERY OR CREMATORY: Greenway
24D. LOCATION (City, town, or county) (State): Berkeley Springs W Va

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A C Higinbotham, ADDRESS: Elkins City Md

VS 150

124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80280

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 Registered No. C80280

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK LEWINSKY

2. DATE OF DEATH: Nov 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Maryland Hospital
c. Length of stay in Baltimore: Year 24 Mos Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: FLORIDA
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Key West
D STREET ADDRESS (If rural, give location): 526 DUVAL ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | white | married | 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | RETIRED | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wolf Lewinsky | Ellen |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | H. Lewinsky | same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia
DUE TO
(B) Chronic Glomerular Nephritis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/4 19[illegible] *to* 11/28, 1949, *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* [illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E Hoel, J M. D. | U of Md. Hospital | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 30/49 | Alliance Cemetery | Norma New Jersey |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Sol Levinson Bro. | W North ave 1310 |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G80281

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

587 ✓ Registered No. G80281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Marian Watson

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 N. Chapel St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 3 N Chappel St 6-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | Nov 2nd 1949 | | 23 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Watson | Lucile A Wilson |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs Watson | 3 N Chappel St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fibrocystic disease of the pancreas | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Rogers M.D. | | Nov. 25, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 28th 1949 | Mountlands | Taylor Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Leo Deach | 1703 N. Patterson Park Ave |

VS 151

1579 ✓

BURTON. ✓

G80282 — BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

331 — Registered No. G80282

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Burton, Lillian

2. DATE OF DEATH: 11/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore: 49 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN. (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 614- Sara Ann St. 4-0 ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | B | S | 11-6-1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10B. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE

11. BIRTHPLACE (State or foreign country): BALTO. MD

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William ROYSTER

14. MOTHER'S MAIDEN NAME: MAMIE - ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ALONZO ELLIOTT — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Essential Hypertension

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/23, 1949, *to* 11/23, 1949, *that I last saw the deceased alive on* 11/23, 1949, *and that death occurred at* 10:30 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wm. Norman M. D.

23B. ADDRESS: Univ. Hosp.

23C. DATE SIGNED: 11/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: 11-28-49

24C. NAME OF CEMETERY OR CREMATORY: MT. AUBURN

24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949

REGISTRAR'S SIGNATURE: Registrar of Vital Statistics

25. FUNERAL DIRECTOR — ADDRESS: William a Jackson 916 Penna ave

VS 150

83a

VS-139-28

G80283

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80383

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Haywood

2. DATE OF DEATH: 11-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: Yrs. Life / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 916 Pine Street 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | Aug. 8, 1912 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Md | |

13. FATHER'S NAME: Ernest Haywood

14. MOTHER'S MAIDEN NAME: Eleanor Queen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | RECORDS*BALTO. CITY HOSPITALS 4940 EASTERN AVE. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pulmonary tuberculosis — DUE TO

(C) Intestinal distention

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 3-9- 19 49 *to* 11-20 19 49, *that I last saw the deceased alive on* 11-20 19 49, *and that death occurred at* 10:55 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Avenue | 11-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Mt. Calvary | 3808 S. Hanover |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 28 1949 | Hunter for Williams, M.D. | William A. Jackson 13 D 916 Penna ave |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80284 ✓ Yr. 1 G80284

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Carrie Boyer

2. DATE OF DEATH: Nov. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 436 E. 21st St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 436 E. 21st St. 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | June 9, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | A. A. Co., Md. | |

13. FATHER'S NAME: John P. Comegys

14. MOTHER'S MAIDEN NAME: Georgiana Mitchell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Thomas L. Boyer | 10 S. Bernice Av. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiac — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Vascular Disease —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| Earl L. Boyer | | | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/30/49 | Mt. Olivet Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

939

G80385

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No.

G80385

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): William T.Trautman

2. DATE OF DEATH: Nov.25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3307 Gibbons Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
3307 Gibbons Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 3307 Gibbons Ave. 27-44

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Nov.26.1886 | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supt.Overhead Lines | Balto. Transit | Balto. Md. | |

13. FATHER'S NAME: ---Trautman

14. MOTHER'S MAIDEN NAME: Mary---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-05-9873

17. INFORMANT: Mrs.Mary M.Trautman, ADDRESS 3307 Gibbons Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
(B) Arteriosclerosis
associated
Acute myocardial decompensation — 2 days
Right Hemiplegia — 2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November 24, 1949 *to* November 25, 1949, *that I last saw the deceased alive on* Nov 24, 1949 *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. W. Harlold M. D. | 4206 Harford Road | Nov. 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov.29/49 | Parkwood Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington for Williams, M.D. | Philip Henry Sons | 2024 Orleans St. |

VS 150

93D

G80386

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80386

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Thomas

2. DATE OF DEATH: 11-24-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 21 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD.
B. COUNTY: Crownsville State Hospital
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore( Crownsville State Hospital
D. STREET ADDRESS (If rural, give location): Crownsville State Hospital (Rural)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Div. | Sept. 13 1906 | 43 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Fla. | |

13. FATHER'S NAME: Deceased

14. MOTHER'S MAIDEN NAME: Deceased

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | B.C.H. Records | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Post Operative Intra-pleural hemorrhage | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Lung Abscess | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-24-49 | Lung Abscess | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10- 17- , 1949 , *to* 11- 24- , 1949 *that I last saw the deceased alive on* 11- 24-49, *and that death occurred at* 4.55 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. C. Rogers M. D. | B.C.H. 4940 Eastern Ave. | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 11/28/49 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Chas. R. Law | 802 Madison Ave. |

VS 150

114D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80287

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 923.0 G80287

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): GEORGE F. REIER N-968.0

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3909 Gwynn Falls Parkway 15-49

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 6/30/11
9. AGE (In years last birthday): 38 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Jewel Laundry
11. BIRTHPLACE (State or foreign country): Balto. Md
12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Geo. E. Reier
14. MOTHER'S MAIDEN NAME: Maud M. Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown
16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 212-07-5203
17. INFORMANT: Henry W. Reier ADDRESS: 725 West Hills Terrace

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation due to carbon monoxide poisoning
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Garage
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3909 Gwynn Falls Parkway
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 25, 1949 7:30 A m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Carbon monoxide poisoning Hose in mouth-attached to exhaust

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Nov. 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 28/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk.
24D. LOCATION (City, town, or county) (State): 3801 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry H. Nitske ADDRESS: 4101 Edmondson Ave

VS 151

163 NN

G80288

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44

G80288

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Wallace

2. DATE OF DEATH: 11/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 234 Douglas Court

c. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 234 Douglas Court 6-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Strike out) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | ~~Widowed~~ Married | Dec. 20, 1866 | 83 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James kirby

14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Clifton Wallace ADDRESS: 1804 Madison Ave., Balt.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) hypertensive cardio-renal disease (uremia) — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) 1

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: arterio-sclerosis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/17, 1949 *to* 11/25, 1949 *that I last saw the deceased alive on* 11/23, 1949 *and that death occurred at* 9:10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] 800 EAST BALTIMORE MADISON MD

23B. ADDRESS: BROWNE, M. D.

23C. DATE SIGNED: 11.28.49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/28/49 | Arbutus Memorial | Arbutus, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Charles H. Alexander | 1200 McCulloh St. |

VS 150

Balt. Md.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80289

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

61 Registered No. G80289

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Julian J. Malaszek.

2. DATE OF DEATH: 25 Nov. 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland — 23 S Ann St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. 7 Mos. 0 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City.
D. STREET ADDRESS (If rural, give location): 23 S. Ann St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH
9. AGE (In years last birthday): 62 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? I

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Maryanna Malaszek

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Larynx with metast. — (INTERVAL BETWEEN ONSET AND DEATH) 1946) Decs 35 Mos
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Coronary Disease — ?

19A. DATE OF OPERATION: June 1947
19B. MAJOR FINDINGS OF OPERATION: Carcinoma Larynx
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1947 to 25 Nov, 1949 that I last saw the deceased alive on 24 Nov, 1949, and that death occurred at 1:58 P m., from the causes and on the date stated above.

23A. SIGNATURE: Arthur J Siwinski M. D.
23B. ADDRESS: 214 Medical Arts Bldg
23C. DATE SIGNED: 25 NOV 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 29 49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Kenneth for Williams, M.D.
25. FUNERAL DIRECTOR: Fred W Ozarowski
ADDRESS: 470 & 930 Eastern Ave

VS 150

Register writes PERMANENTLY, with UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80290

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 443

Registered No. G80290

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah Hugdin

2. DATE OF DEATH: 11/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-C
D. STREET ADDRESS (If rural, give location): 525 Bloom St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col | Widow | 9/26/1894 | 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | at Home | VA. | USA. |

13. FATHER'S NAME: Humphrey Diggs

14. MOTHER'S MAIDEN NAME: Margaret Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT: Margaret Hugdin ADDRESS: 526 Bloom St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive C.V. Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Rogers M D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 27 Nov 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | First Baptist | Mathews Co, Va. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Joseph A. Lively ADDRESS: 661 W. Barre St. 93D

VS 151

PLEASE WRITE PLAINLY, WITH UNFADABLE INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G8029T

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

601

Registered No. G8029T

BIRTH NO. 48-20271

1. NAME OF DECEASED (Type or Print) LONG, Robert

2. DATE OF DEATH Nov 26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2407 Ellamont St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2407 Ellamont St

C. Length of stay in Baltimore Life time Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 2407 Ellamont
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md
D. STREET ADDRESS (If rural, give location) W - 37

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | White | | Sept Dec 22nd 1948 | 1 year 2 mo | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Long

14. MOTHER'S MAIDEN NAME Arlene Fasland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Charles Long ADDRESS 2407 Ellamont st

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory Failure
DUE TO
(B) Hydronephrosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MAY, 1949 *to* Nov 26, 1949, *that I last saw the deceased alive on* Nov 25, 1949, *and that death occurred at* 6.00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE I. Shorofsky M.D. M. D.

23B. ADDRESS 601 N. Monroe St.

23C. DATE SIGNED 11/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec. 28th

24C. NAME OF CEMETERY OR CREMATORY London Park

24D. LOCATION (City, town, or county) (State) Sexton R.

DATE RECEIVED BY LOCAL REGISTRAR NOV 28 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR A. Jones ADDRESS 601 Hold Wood P K W

VS 150

1336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80392

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80392 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Francis Montgomery

2. DATE OF DEATH: Nov 24 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2332 Guilford Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mo. Days

D. STREET ADDRESS (If rural, give location): 2332 Guilford Ave

5. SEX: Male | 6. COLOR OR RACE: Col. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower | 8. DATE OF BIRTH: May 21 1876 | 9. AGE (In years last birthday): 73 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Prince George County Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Montgomery

14. MOTHER'S MAIDEN NAME: Cutie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Louis Spriggs ADDRESS: 2332 Guilford Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage 3 days.

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerosis

DUE TO

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 21 19 49 *to* Nov 24 19 49 *that I last saw the deceased alive on* Nov 24 19 49 *and that death occurred at* 8:— *m., from the causes and on the date stated above.*

23A. SIGNATURE: James A Fellows M. D.

23B. ADDRESS: 2329 Guilford Ave.

23C. DATE SIGNED: Nov 25 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov 28 49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.

24D. LOCATION (City, town, or county) (State): B.C. County Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Thos. Robt. C. Elliott Funeral

ADDRESS: 1129 N. Caroline St

VS 150

832

Please write the cause of death clearly and legibly. Physician: please write the correct age in especially important.

G80393

G80393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Andrew Melvin Tyler

2. DATE OF DEATH: Nov 26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17 03
D. STREET ADDRESS (If rural, give location) 2453 Brentwood Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2453 Brentwood Ave

c. Length of stay in Baltimore: Yrs. 50yrs. Mos. Days

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Feb 22 1888
9. AGE (In years last birthday): 61 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Portia Ellen Burgess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mable Burgess ADDRESS: 2453 Brentwood Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Lung of.
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* Nov. 1 19 49 *to* Nov. 26 19 49, *that I last saw the deceased alive on* Nov. 26 19 49, *and that death occurred at* 4:17 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 329 Cumberland Ave.
23C. DATE SIGNED: Nov 29 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 27/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.
24D. LOCATION (City, town, or county) (State): B.C. County Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Robert G. Elliott & Daughter
ADDRESS: 471 1129 N. Carrollton

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80294

G80294

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 41 0

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary A Moore

2. DATE OF DEATH: Nov 24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1904 Division St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 60+ Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 1403

5. SEX: Female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: May 20-1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none (Home)
10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Michael Wheeler
14. MOTHER'S MAIDEN NAME: Sarah Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: Ella Weems ADDRESS 1904 Division St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

DUE TO

(B) Arthritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 13, 1949 *to* Nov 24, 1949 *that I last saw the deceased alive on* Nov 24, 1949 *and that death occurred at* 8 50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Edward Fisher M.D.
23B. ADDRESS
23C. DATE SIGNED: Nov 25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 28/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State): Westport Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Ethel A. Elliott
ADDRESS: 920 1129 N. Carlton St.

VS 150

Physician: please write the cause of death clearly and legibly. Correct age is especially important.

G80295 BALTIMORE CITY HEALTH DEPARTMENT G80295

# CERTIFICATE OF DEATH

177 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BRANCH, RICHARD

2. DATE OF DEATH Nov. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2338 N. Gilbert St.

C. Length of stay in Baltimore 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-03

D. STREET ADDRESS (If rural, give location) 2338 N. Gilbert St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | Dec. 24, 1868 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chef Cook | | Nottaway C. Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Branch | Minerva Branch |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs. Susie Branch | 2338 N. Gilbert St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma prostate

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 23, 1949, to Nov 26, 1949 *that I last saw the deceased alive on* Nov 26, 1949 *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Shorofsky M. D. M. D. | 601 N Monroe St. | 11/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 29, 1949 | Mt. Calvary | Prince Georges Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

51B

Please write very plainly. Use ink. Do not use pencil. Be sure that every item is correctly supplied. Accuracy and completeness of statements in this certificate are especially important. Physicians: please write the cause of death clearly and legibly.

G80396

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

171 Registered No. 3691

G80396

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances Rhenbottom

2. DATE OF DEATH: Nov. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1343 N. Stricker St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1343 N. Stricker St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | Dec. 23, 1905 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Lancaster Co. Va | U. S. Cit |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Carter | Betty Taylor |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Samuel Rhenbottom | 1343 N. Stricker |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Cervix — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 7-4-, 1949, *to* 11-25, 1949, *that I last saw the deceased alive on* 11-25-, 1949, *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jno. B. Saunders M. D. | 1029 N. Stricker St. | 11-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 28, 1949 | Mt. Auburn | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams M.D. | Holland Funeral Home | 1031 Druid Hill Ave 48a |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80397 BALTIMORE CITY HEALTH DEPARTMENT G80397

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Joseph Williams N-807 — 2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1026 Argyle St. 17-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | March 6, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Same | Maryland | |

13. FATHER'S NAME: Phillip Williams
14. MOTHER'S MAIDEN NAME: Louisa Henry

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W. I | | Ella Snowden | Myrtle Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary embolism | |
| | DUE TO (B) Multiple fractured ribs, left | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | excavation | Winslow near Bentlow Sts. 15/4 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 15, 1949 8 A. m. | WHILE AT WORK ☒ NOT WHILE AT WORK ☐ | steamShovel Pt. struck in rt. chest post. with |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | | Nov. 27, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Balto. National | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Tunstall Williams M.D. | MRS. KATIE R. WILLIAMS | Schroeder St. |

VS 151

176 Mrs Katie R Williams

G80298

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.1

G80298

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): CABELL R. ANDERSON

2. DATE OF DEATH: November 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
c. Length of stay in Baltimore: 35 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 417 E. 24th Street 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | widowed | Aug. 29, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| janitor | | Danville, Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick Anderson | Eliza E. Moore |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War I | none | Mrs. Edith Mack | 936 Harlem Avenue |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage
DUE TO
(B) ruptured esophageal varices

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
XXXXX
(C) Cirrhosis of liver

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* partial autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [ ], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Carl L. Reese M.D. | ASSISTANT MEDICAL EXAMINER [X] | 9-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | November 29th 49. | Baltimore National Cemetery. | Baltimore, Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Clifford L. Henson. | 1120 Biggle Ave. City |

VS 151

124B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80299 G80299

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

445 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Louisa Dorothy Merson

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1907 E. Oliver Street 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Fe. | White | Married | Feb 7 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Wife. | | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Archilball Cook

14. MOTHER'S MAIDEN NAME: Margaret Schnalbel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ------ | 219-18-2874 | Margaret Merson | 1907 E Oliver St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant hypertension — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ..... DUE TO

(C) .....

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/8/ , 1949 *to* 11/26/ , 1949 *that I last saw the deceased alive on* 11/26/ , 1949 *and that death occurred at* 12:30 PM. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Dwinski M. D. | 1400 N. Caroline Street | 11/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 29 1949 | Holy Redeemer Cemetery | 4430 Belair Rd Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Duffel Bro. | 1800 ELombard St, |

VS 150

102

...ORDS, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80300

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 420.1

G80300

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Bergler

2. DATE OF DEATH: Nov. 28 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 S CASTLE ST.
c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 2-01
D. STREET ADDRESS (If rural, give location): 108 S. Castle St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | Single | Aug 4 - 1860 | 89 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Balto. Md. | U.S.A. |

13. FATHER'S NAME: Andrew Bergler

14. MOTHER'S MAIDEN NAME: Barbara ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Bergler ADDRESS: 108 S Castle St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Nov 28 49

DUE TO

(B) Chr. Myocarditis. Jan 1944

DUE TO

(C) Generalized Arterio Sclerosis 1940

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 1940 *to* Nov 28 1949, *that I last saw the deceased alive on* Nov 28 1949, *and that death occurred at* 6 30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Bauer M. D. | 801 E Lexington St | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 30-49 | Holy Redeemer | 4600 Belair Rd Balto Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Dippel Bros ADDRESS: 1800 E. Lombard St.

VS 150

93D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G8030T

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

5 93

Registered No. G80301

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH C. FLOYD

2. DATE OF DEATH 11/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 316 Myrtle Av

C. Length of stay in Baltimore 20yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, City, Md
D. STREET ADDRESS (If rural, give location) 316 Myrtle Av 4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Widowed | 4/16/1894 | 55 | 7 | 9 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Construction | Va. | U.S.A. |

13. FATHER'S NAME Charles Floyd

14. MOTHER'S MAIDEN NAME Mary ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | No | | Grace Hawkins (D) | 316 Myrtle Av. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO

(B) Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/22 19 49 *to* 11/25 19 49 *that I last saw the deceased alive on* 11/25 19 49 *and that death occurred at* 1:40 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph W. Reilly M.D. | 4 E. Northway | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/29/49 | Mt. Auburn Cemetery | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Chas. L. Ogden | 5412 Eastern Av. |

1318

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80302
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80302

1. NAME OF DECEASED (Type or Print): ALOYSIUS DORN
2. DATE OF DEATH: 11/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): S. Bets Gen. Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 435 Freeman St. 25-07

5. SEX: M.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M.
8. DATE OF BIRTH: 12-8-1896
9. AGE (In years last birthday): 53 | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mach. Operator
10B. KIND OF BUSINESS OR INDUSTRY: Eastern Bag Co.
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Conrad
14. MOTHER'S MAIDEN NAME: Eliz. Fusel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Family - Same. ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Congestive heart failure
DUE TO
(C) Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/25/49 to 11/27/49, that I last saw the deceased alive on 11/27/49, and that death occurred at [illegible] m., from the causes and on the date stated above.

23A. SIGNATURE: Haig D. Yazujian M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 11/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): B.
24B. DATE: 11/30/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross.
24D. LOCATION (City, town, or county) (State): Brooklyn.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph L. McCauley ADDRESS: 1302 E. Fort Ave

VS 150
HAIG D. YAZUJIAN
94a

G80303

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80303

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANDREW BELLEGAS

2. DATE OF DEATH: Nov 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23 01
D. STREET ADDRESS (If rural, give location): 1438 E. Chase St ~~Balt. Co.~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Chinese | Married | May 29, 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Restaurant | Restaurant | China | Chinese |

13. FATHER'S NAME: Mr Koon Bellegas

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| Unknown | | Mrs. G - Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of unknown origin with metastases to the liver — INTERVAL BETWEEN ONSET AND DEATH: 3 months?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Central Nervous System Syphilis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-17, 1949, *to* 11-26, 1949, *that I last saw the deceased alive on* 11-26, 1949, *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry Clinton Stanford M. D. | Union Memorial Hospital | 11-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 11-29-49 | Loudon Park | Balto. Frederick Co |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | James L. McCarney - 1302 Fort Ave |

VS 150

55E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80304

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80304

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HUMPHREY WARREN BUCKLER, SR.

2. DATE OF DEATH: 28 NOVEMBER, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 806 CATHEDRAL ST.
c. Length of stay in Baltimore: 75 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 806 CATHEDRAL ST.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | OCT. 17, 1874 | 75 | 1 / 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PHYSICIAN. | MEDICAL | BALTIMORE, Md. | U. S. A. |

13. FATHER'S NAME: RIGGIN BUCKLER, M.D.

14. MOTHER'S MAIDEN NAME: ALICE L. RIGGS

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | H. WARREN BUCKLER, JR. | BALTIMORE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary occlusion | 18 hrs. |
| DUE TO (B) | Arteriosclerosis - severe. | ? years. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July, 1948, *to* 28 November 1949, *that I last saw the deceased alive on* 28 Nov., 1949, *and that death occurred at* 9:30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Douglas Lockard, M. D. | 802 Cathedral St. | 28 Nov 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 30 Nov. 1949 | ST. THOMAS' CHURCH YARD | GARRISON FOREST, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Registrar for Records, M.D. | Walter Brooks Bradley, | Dundalk, Baltimore 22 |

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80305 X G80305

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
17° Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET CABELL BOLES
2. DATE OF DEATH: 11/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: Yrs. 1 Mos. 6 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: PENN.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PUNXSUTAWNEY
D. STREET ADDRESS (If rural, give location): 911 E. MAHONING ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | S | MAY 4, 1890 | 59 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TEACHER
10B. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (State or foreign country): COLORADO
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: OSCAR E BOLES
14. MOTHER'S MAIDEN NAME: LUCY R. BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO: None
17. INFORMANT: MRS. J. HARRY GROSS
ADDRESS: SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) HEPATIC METASTASES OF CARCINOMA
DUE TO
(B) CARCINOMA OF BREAST
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: June 22, 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of breast (from duct epithelium) with axillary metastases
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/21, 1949, *to* 11/27, 1949, *that I last saw the deceased alive on* 11/27, 1949, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John D. Green III M. D.
23B. ADDRESS: Union Memorial Hosp.
23C. DATE SIGNED: 11-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Nov 29/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Crem.
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Curator of Vital Statistics, Md
25 FUNERAL DIRECTOR: Stewart & Mowen Co.
ADDRESS: 108 W. North Ave

50 City #1.

Please write plainly with pen or pencil. Every item of information should be correctly supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

ES-133562 G80306

G80306

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 33

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JANE Hannah Bowerman

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4917 Alhamba Street (12)

27-10

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 21, 1871
9. AGE (In years last birthday): 78 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse
10B. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: B James Bowerman (D)

14. MOTHER'S MAIDEN NAME: Hannah J. Hammond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchial Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-18, 1949, *to* 11-25, 1949, *that I last saw the deceased alive on* 11-25-49, *and that death occurred at* 11:10 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Rogers M. D.
23B. ADDRESS: 4940 EASTERN AVENUE
23C. DATE SIGNED: 11-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 29 49
24C. NAME OF CEMETERY OR CREMATORY: St. Stephens Cemetery
24D. LOCATION (City, town, or county) (State): Bradshaw, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Ruth for Williams M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108 W. North Ave.

838 City #1.

Physician: please write the cause of death clearly and legibly.

Dr Serra
(980307 Hopkins drive.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80307
Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) Elizabeth Bellistri | 2. DATE OF DEATH Nov. 27-1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3500 Echodale Ave<br>C. Length of stay in Baltimore Yrs. Mos. Days | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 24-44<br>D. STREET ADDRESS (If rural, give location) 3500 Echodale Ave. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widowed | July 9-1880 | 69 | 4 | 18 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Italy | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Vincent Silvestri | Angela |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | |
|---|---|---|---|
| | | Mrs. Theresa Anderson | 3500 Echodale |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Stomach with | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Metastases | 18 mo |
| DUE TO | | |
| | (C) Myocardial degeneration & failure | 5 yrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| None | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* August, 19 41, *to* Nov 27, 19 49, *that I last saw the deceased alive on* 11/26, 19 49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lawrence DiLeva M. D. | 11 E. Chase St | 11/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-30-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Thurlington Williams, MD | Leonard J. Luck | 5305 Harford. |

VS 150

46 R

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80308

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

59 ✓ Registered No.

G80308

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE RIGDON

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 309 N. CENTRAL AVE
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 5-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO
D. STREET ADDRESS (If rural, give location): 309 N. CENTRAL AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C. | SINGLE | 9-10-93 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| DOMESTIC | | Md | |

13. FATHER'S NAME: SAMUEL RIGDON

14. MOTHER'S MAIDEN NAME: SARAH PURVIANCE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | LOTTIE LEE | 507 N. CENTRAL AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Chronic Nephritis — ?

DUE TO

(C) Hypertension — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 2-1-, 1949, *to* 11-25, 1949 *that I last saw the deceased alive on* 11-25, 1949, *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard P. Amrando M.D. | 2209 Druid Hill | 11-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-29-49 | Mt CALVARY | BALTO. COUNTY, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Lemuel Williams, M.D. | Joseph S. Rocks Jr | 1310 N. Central Ave |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1310

G80309

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80309

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GERTRUDE DAVIS
2. DATE OF DEATH: 11-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 30 S. CARLTON ST
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO 18-03
D. STREET ADDRESS (If rural, give location): 30 S. CARLTON ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C. | MARRIED | 8-14-1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| DOMESTIC | | Md | |

13. FATHER'S NAME: WM. H. JOHNSON
14. MOTHER'S MAIDEN NAME: HELEN HAZELTON

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | LILLIAN PAYNE 810 Appleton St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO

(B) Hypertensive Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 27, 1949, *to* Nov. 26, 1949, *that I last saw the deceased alive on* Oct. 27, 1949, *and that death occurred at* 12:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Williams Washington Jr. M. D. | 18-35 W. Lexington St | Nov. 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 11-30-49 | MT. CALVARY | A. A. County, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 28 1949 | Tuntington Williams, M.D. | Joseph B. Locke, Jr. 1304 N. Central Ave |

VS 150

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80310

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4201 G80310

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) JOHN L. DONELLEN (Donellan)

2. DATE OF DEATH Nov. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
C. Length of stay in Baltimore Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1413 Mt. Royal ave. 14-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Divorced | Dec. 4/1884 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Lumber Co. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME James Donnellan

14. MOTHER'S MAIDEN NAME Catherine Hanrahan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT 3007 Cresmont ave. Mrs. M. Frank Fitzpatrick

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary occlusion | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Arteriosclerosis | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | Nov. 23, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/30/49 | New Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Permit from Williams, M.D. | Chas. F. Covert & Son Inc. | 94a 118 W. Mt. Royal Ave. |

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80317 ✓ 153 G80317

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET B. EVANS

2. DATE OF DEATH: Nov. 27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Paul Court Apts. 3120 St. Paul street
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3120 St. Paul street 12-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Widowed | Oct. 12, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | --- | Timonium, Md. | U.S.A. |

13. FATHER'S NAME: Martin Connor

14. MOTHER'S MAIDEN NAME: Bridget Murray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: --- --

17. INFORMANT: Miss Cecilia Connor 3120 St. Paul street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Sigmoid | 3 yrs |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Metastasis to lung | 1 yr |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 1947 | Carcinoma of Sigmoid Colon | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* July, 1947 *to* Nov 27, 1949, *that I last saw the deceased alive on* Nov 27, 1949, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. W. Ashworth M. D. | 1129 St Paul St | Nov 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | Cathedral | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Lurlington Williams, M.D. | Chas. F. Evans & Son, Inc. | 46E 118 W. MT ROYAL AVE |

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80312 ✓ 331 G80312

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Josephine D. Plunkett

2. DATE OF DEATH: Nov 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1205 E Lakeside Ave

C. Length of stay in Baltimore: 60 Years

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 609 E. 38th St 9-01

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ ~~DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: Feb 27 1865
9. AGE (In years last birthday): 84
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Cuglio De Pasquale
14. MOTHER'S MAIDEN NAME: Louisa Fontine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS: Mrs R. Lamar Payor 1205 Lakeside Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 27, 1949, to Nov. 25, 1949, *that I last saw the deceased alive on* Nov 24, 1949, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: I. Emmett Green M. D.
23B. ADDRESS: 101 W. Read St. Baltr.
23C. DATE SIGNED: Nov 26 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov 29 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem
24D. LOCATION (City, town, or county) (State): Old Frederick Road

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Penelope Lee Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Gordon J. Moran 4201 York Road

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

8 3a

G80313

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Rev. 1 G80313 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANCIS R. CROSS

2. DATE OF DEATH: Nov. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 526 W. University Pkwy.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 526 W. University Pkwy. 13-07

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | July 26, 1890 | 59 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| General Attorney | Railroad | Baltimore, Md. | |

13. FATHER'S NAME: Eben J. Cross

14. MOTHER'S MAIDEN NAME: Ann Dickey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes | | Mrs. Helen M. Cross | 526 W. University Pkwy |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3½ years
DUE TO
(B) arteriosclerosis — ?
DUE TO
(C) Cerebral Vascular accident — 1 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 3/21/46, 19__, *to* 11/27, 1949, *that I last saw the deceased alive on* 11/7, 1949, *and that death occurred at* 9:20 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis W. Fluck M. D. | 3406 St Paul St | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/29/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Esther for Williams M.D. | WM. J. TICKNER & SONS | Balto., Md. |

8

94a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80312 BALTIMORE CITY HEALTH DEPARTMENT G80312

# CERTIFICATE OF DEATH

BIRTH NO. 16 Registered No. 30314

1. NAME OF DECEASED (Type or Print): John McGiff

2. DATE OF DEATH: 11/28/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 901 Furrow St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 2, 1889
9. AGE (In years last birthday): 60 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph McGiff
14. MOTHER'S MAIDEN NAME: Agnes Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Bertha L. McGiff ADDRESS: 901 Furrow St.

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mediastinitis, pneumothis — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

(B) Bronchogenic carcinoma, right side.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 21, 1949 to Nov 28, 1949, that I last saw the deceased alive on Nov. 28, 1949, and that death occurred at 5:20 A m., from the causes and on the date stated above.

23A. SIGNATURE: Wm B Camp M. D.
23B. ADDRESS: Franklin Square Hosp
23C. DATE SIGNED: 11-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 1-1949
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cemetery
24D. LOCATION (City, Town, or County) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949
REGISTRAR'S SIGNATURE: Temperance Williams, M.D.
25. FUNERAL DIRECTOR: George L. Schwab ADDRESS: 2101 Eutaw Ave

47c

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80315 G80315

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): William F. J. Smith
2. DATE OF DEATH: NOV. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1414 Forge Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto
D. STREET ADDRESS (If rural, give location): 1414 Forge Ave 27-15

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4/27/1880
9. AGE (In years last birthday): 69 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Watchman
10B. KIND OF BUSINESS OR INDUSTRY: Md. Nut & Bolt Co
11. BIRTHPLACE (State or foreign country): Rockland Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Smith
14. MOTHER'S MAIDEN NAME: Priscilla Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Florence C. Smith ADDRESS: 1414 Forge Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammerer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: NOV. 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/30/49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood
24D. LOCATION (City, town, or county) (State): Parkville Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Cuthbert Williams M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 151

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80316 G80316

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1997 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN CHLAD — N-968
2. DATE OF DEATH: Nov. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3906 Ednor Rd.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3906 Ednor Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3906 Ednor Road — 9-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | 8/17/89 | 54 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Letter Carrier | U.S. Post Office | Balto. | |

13. FATHER'S NAME: John Chlad
14. MOTHER'S MAIDEN NAME: Mary (Unknown)

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W. I | | Lorraine E. Chlad | 3906 Ednor Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon Monoxide Poisoning
DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3906 Ednor Rd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Between 11-17--11-27-49 ?m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? 4 jets on gas burner turned on but unlit

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. L. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11/30/49
24C. NAME OF CEMETERY OR CREMATORY: Wm. S. National
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 127 St. Paul St.

VS 151

163H

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80317

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 163

G80317

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM F. TURNER

2. DATE OF DEATH Nov. 26, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1115 Valley St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1115 Valley St. 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 28, 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Starter, Cab, retired | Yellow Cab Co | Baltimore, Md. | |

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | Spanish American | | Vernon L. Turner | 1115 Valley St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6-1, 1949 *to* 11-26, 1949, *that I last saw the deceased alive on* 11-25, 1949, *and that death occurred at* 10:05 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. O. Flynn, M. D. | 11 E. Chase St. | 11-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/29/49 | Lorraine Park | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Emily Jo Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

47D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80518 G80518

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 470.1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lizzie Affelder

2. DATE OF DEATH: Nov. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1700 Eutaw Pl.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 1700 Eutaw Place 14-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 5, 1864
9. AGE (In years last birthday): 84 yrs (If under 1 year: Months 11, Days 22; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Max Affelder
14. MOTHER'S MAIDEN NAME: Yetta Schopflacher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Samuel J. Fisher ADDRESS: 08 Sullivan Bldg.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Arteriosclerosis - advanced

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 29 *to* Nov. 27, 19 49 *that I last saw the deceased alive on* Nov. 27, 19 49 *and that death occurred at* 5P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis Spaeth, M. D.
23B. ADDRESS: 1700 Eutaw Place
23C. DATE SIGNED: Nov-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 28. 1949
24C. NAME OF CEMETERY OR CREMATORY: Har Sarni Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Victoria for Williams, M.D.
25. FUNERAL DIRECTOR: David Sondheim & Son. ADDRESS: 1902 Eutaw Pl.
David Sondheim & Son 94a

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80319 ✓ G80319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 581.0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Molly Dugan

2. DATE OF DEATH: 11/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): Levindale Home for Aged

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: 55 Yrs. ~~Mos.~~ ~~Days~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Paul | Mary |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Hilda Caplan | 1702 N Smallwood St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cirrhosis of Liver | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Diabetes Mellitus, Arteriosclerotic CVD | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/27, 1949 *to* 11/28, 1949, *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* 5 18 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Max Miller M. D. | Sinai Hospital | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-29-49 | Hebrew Mt Carmel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV | Courtesy of [illegible] | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

61

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80320

BIRTH NO. 4 v 0. 1 Registered No.

1. NAME OF DECEASED (Type or Print): BENJAMIN GINSBERG

2. DATE OF DEATH: 11-28-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-W
D. STREET ADDRESS (If rural, give exact address or location): 2101 Cartendale Road

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give exact address or location): 2101 Cartendale Road

5c. Length of stay in Baltimore: 45 Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 6 | 73 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Hat Mfg | Russia | |

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Elizabeth Ginsberg | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) arteriosclerotic cv. disease — DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 1 hr; (B) 3 yrs

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 25, 1949 *to* Nov 26, 1949 *that I last saw the deceased alive on* Nov 26, 1949, *and that death occurred at* 10:15 A. m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Paul S. Corliss M.D. M. D. | 242 South Ave | 11/28/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-30-49 | Hebrew Friendship Mem | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 2 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80321

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 331

C80321 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HANNAH PEAR BRENNER

2. DATE OF DEATH: 11-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2302 Tioga Parkway
c. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15th
D. STREET ADDRESS (If rural, give location): 2302 Tioga Parkway

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 70 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Latvia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Not Known Henry
14. MOTHER'S MAIDEN NAME: Ethel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Henry Brenner ADDRESS: 2302 Tioga Parkway

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — 3 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C) Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 5-1949 *to* Nov-28-1949, *that I last saw the deceased alive on* Nov-28-1949 *and that death occurred at* 12 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr. Herman Leidl M. D.
23B. ADDRESS: 2404 Eutaw Pl
23C. DATE SIGNED: 11-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-29-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Gem
24D. LOCATION (City, town, or county) (State): Hagerstown Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29
REGISTRAR'S SIGNATURE: Henrietta [illegible]
25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

C80,322

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. C80,322

1. NAME OF DECEASED (Type or Print): Mary Ellen Viehmeyer
2. DATE OF DEATH: Nov. 27, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 1433 Patapsco St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1433 Patapsco St
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb. 26, 1873
9. AGE (In years last birthday): 76 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? U-S
13. FATHER'S NAME: George H Rush
14. MOTHER'S MAIDEN NAME: Mary —
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): one
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mrs Carrie Klopein ADDRESS: 1433 Patapsco St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B)
DUE TO
(C) Arteriosclerosis Hypertension
Cirrhosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 8 , 19 49 *to* Nov 27 , 19 49 *that I last saw the deceased alive on* Nov 26 , 19 49 *and that death occurred at* 9a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Arthur A. Schenck M. D.
23B. ADDRESS: 1337 S. Charles St.
23C. DATE SIGNED: 11/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 30 1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Leland Ellis ADDRESS: 1410 Charles St

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

C80323 C80323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 201

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mr. Joseph Henry Turner

2. DATE OF DEATH Nov. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 100 Burnett St. 23-01

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH March 13, 1885
9. AGE (In years last birthday) 64. If under 1 Year: Months, Days. If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10B. KIND OF BUSINESS OR INDUSTRY (Unemployed)
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles J. Turner
14. MOTHER'S MAIDEN NAME Rebecca Allison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO 215-16-9259
17. INFORMANT Mary E Dew
ADDRESS 538 E 21st Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgkin's Disease with ruptured spleen

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (B)
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/18/ , 1949 *to* 11/26/ , 1949 , *that I last saw the deceased alive on* 11/26/ , 1949 *and that death occurred at* 8:20 AM *m., from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Sturniolo M. D.
23B. ADDRESS 1100 N. Caroline Street
23C. DATE SIGNED 11/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Nov. 30, 1949
24C. NAME OF CEMETERY OR CREMATORY Mt Olivet
24D. LOCATION (City, town, or county) (State) Balt Md

DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR H. Gaard Ellwood & Son
ADDRESS 1405 Eutaw Pl

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

446

G80324 G80324

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 4201 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMILIE DEBUS

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3006 Woodland Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3006 Woodland Ave. 27-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | July 2, 1870 | 79 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Karl Figge | Louise Giesler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Carl Debus | 3006 Woodland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Coronary Thrombosis | 1 day |
| DUE TO (B) | Arterio Sclerosis — | 10 yrs |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 26 — , 1949, *to* Nov 26 — , 1949, *that I last saw the deceased alive on* Nov 26 , 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Gill Grall M.D. | 1631 E North Ave | Nov 26-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/29/49 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680325 ✓ 680325

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 163 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): VERNON M. JETT

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 798 Grantley St. 1608

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 798 Grantley St.

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 7, 1892 | 57 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | Venetian Blinds | Baltimore, Md. | |

13. FATHER'S NAME: Wm. M. Jett

14. MOTHER'S MAIDEN NAME: Lula Bangs

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 212-14-8228 | Mrs. Anne M. Jett | 798 Grantley St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Lung.
DUE TO
ANTECEDENT CAUSES
(B) Bronchopneumonia.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 6, 1949 *to* Nov 25, 1949 *that I last saw the deceased alive on* Nov 25 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton Susman M.D. | 1429 W Fayette St | Nov 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/29/49 | Meadow Ridge Cem. | Howard Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

47

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80326 ✓ C80326

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 141

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY HUDSON

2. DATE OF DEATH: Nov. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 922 N. Charles St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 922 N. Charles St. 11-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Aug. 1, 1864 | 85 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| salesman ~~xxki~~ | Retail Coffee | Webster, Mass. | |

13. FATHER'S NAME: Frank Hudson

14. MOTHER'S MAIDEN NAME: Mary McCusker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Mary Hudson | 922 N. Charles St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coma g Tongue — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

(B) None

DUE TO

(C) None

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1946, 19__, *to* 11-26-49, 19__, *that I last saw the deceased alive on* 11-15-49 19__, *and that death occurred at* 1 Am. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Eugene Covington M.D. M.D. | 828 Park Ave. Baltimore, Md. | 11-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/1/49 | Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

458

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80327 G80327

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 177 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Francis Prather
2. DATE OF DEATH: Nov 28th 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 3021 Baker St.
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3021 Baker St. 16-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W. | Widowed | April 21-1880 | 69 | 7 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lawyer | Casualty Co. | Baltimore Md. | U.S. |

13. FATHER'S NAME: Wm F. Prather Sr.
14. MOTHER'S MAIDEN NAME: Sarah Long

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 358-07-7124 | Mrs Isabella V Preston | 3021 Baker St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 1 Yr. 1 Month 18 days.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct. 10-1949 10 hrs/ns | Carcinoma of Prostate | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. I hereby certify that I attended the deceased from May 1- 1949 to November 28, 1949, that I last saw the deceased alive on Nov. 27, 1949, and that death occurred at 12.25p. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. L. Medesmatt M. D. | 1136 Poplar Grove St | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 1-1949 | London Park | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Registrar of Vr. Statistics, Md. | Eastern Pope | 2224 E Chase |

VS 150

51B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80328

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80328 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (FLORA) F. CELESTE DAY HULL

2. DATE OF DEATH NOV. 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) NONE.

c. Length of stay in Baltimore 12 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND. B. COUNTY BALTIMORE CITY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE.
D. STREET ADDRESS (If rural, give location) 5 LONGWOOD ROAD. 27-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | WIDOWED | AUG. 14, 1882 | 67 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE. | NONE. | MARYLAND | U.S.A. |

13. FATHER'S NAME RICHARD RILEY DAY

14. MOTHER'S MAIDEN NAME FLORA MAY THOMAS

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | — | HARRY C. HULL | 4909 ROLAND AVE. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CACHEXIA — INTERVAL BETWEEN ONSET AND DEATH: MAY 1949

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CARCINOMA · HEPATIC DUCT

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| JUNE 16, 1949 | CA. HEPATIC DUCT - METASTASIS TO LIVER | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* MAY 25, 1949, *to* NOV. 29, 1949, *that I last saw the deceased alive on* 11-28, 1949, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arthur Karpen M. D. | 4230 HOCH RAVEN BLVD. | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 1/49 | [illegible] Mt | Frederick Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | [illegible] | Wm R Etchison & Son | Frederick Md |

VS 150

46F

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

680,329 BALTIMORE CITY HEALTH DEPARTMENT 680,329

# CERTIFICATE OF DEATH

Registered No. 4700

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harry S. Feinberg

2. DATE OF DEATH 11/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4220 ParkHeights Ave 15 13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| M | W | W | Oct 17,1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sandwich Shop | | Baltimore Md | |

13. FATHER'S NAME Joseph Feinberg

14. MOTHER'S MAIDEN NAME Minnie Copeland

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Shirley Brown | 4220 ParkHeights Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO
(B) Myocardial Infarction
DUE TO
(C) Arteriosclerosis of Heart

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
A. Hrs.
B.
C.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/23 19 49 *to* 11/28 19 49, *that I last saw the deceased alive on* 11/28 19 49 *and that death occurred at* 7:50 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerry Lasal M.D. | Sinai Hospital | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 30, 1949 | Southern Ave Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 28 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

Vs 458

937

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C-0730 ✓ 680530

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4201

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles A. Barnes

2. DATE OF DEATH: Nov. 25-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3414 Elmora Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3414 Elmora Ave. 8-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 14-1888 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Confectionary | Balto. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Barnes | Minnie Scheidel |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | 220-01-6495 | Rose M. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/23, 19__, *to* 11/25, 1949, *that I last saw the deceased alive on* 11/25, 1949, *and that death occurred at* 8P. m., *from the causes and on the date stated above.*

23A. SIGNATURE M. D.

23B. ADDRESS 2042 Bentalou St

23C. DATE SIGNED 11/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Nov. 28-49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood Mem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 28 1949

REGISTRAR'S SIGNATURE: Evangeline Williams

25. FUNERAL DIRECTOR: John R. Miller

ADDRESS: 2334 Jefferson St

VS 150

94a

C80331 ✓ C80331

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theresa MERBACH

2. DATE OF DEATH: 27 Nov 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 27 N. CAREY ST

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 304 S. Drew St. 26 05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | Jan. 21-1870 | 79 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Balto. Md. | |

13. FATHER'S NAME: Zink

14. MOTHER'S MAIDEN NAME: Not Known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | John Merbach | 304 S. Drew St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis and cardiac degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Advanced arteriosclerotic cardio vascular disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 June, 19 49 *to* 27 Nov, 19 49 *that I last saw the deceased alive on* 27 Nov, 19 49 *and that death occurred at* 2.15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil H. Hennig M. D. | 601 Winans Way | 28 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 30-49 | Holy Redeemer Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Washington Hollander M.D. | John A. Miller | 2334 Jefferson St |

VS 150

927

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80332

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80332 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Olive Mae Haynes

2. DATE OF DEATH: 11 | 28 | 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

C. Length of stay in Baltimore: 41 years (Yrs.) (Mos.) (Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 609 West 33rd St # 11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 12-12-1892 | 56 | 11 | 16 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | West Virginia | USA |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia and acidosis | unknown |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Chronic nephritis | Stones? |
| DUE TO | | over 3 years? |
| | (C) Diabetes mellitus | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | HCURD - Chronic congestive failure | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-28, 1949 *to* 11-28, 1949, *that I last saw the deceased alive on* 11-28, 1949, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Candler M. D. | Maryland General Hospital | 11-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 3, 1949 | St. Mary's | Balto, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Paul E. Campbell Jr. | 3615-17 Clum Chapel Ave. |

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80533 ✓ G80663

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 2282

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ella Green Anderson

2. DATE OF DEATH: Nov. 22 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 606 Brune St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 606 Brune St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widowed | March 9, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | St. Mary Co. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Green | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Grace Blackburn | 606 Brune St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Malnutrition

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/11/95, 19__, *to* 11/27/49, 19__, *that I last saw the deceased alive on* 11/27, 1949, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. Garnett M. D. | 953 Cenest | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov. 30, 1949 | Red Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1651 Druid Hill Ave. 939 |

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80334 ✓ 010 G80334

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES HOWARD PRYOR

2. DATE OF DEATH Nov. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 511 Pennsylvania Ave. 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | col | Married | 6/10/97 | 52 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steel worker | | Va. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Pryor | Fannie Miller |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | ? | Records- US Marine Hospital, Balto, Md. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Meningitis, type undetermined | 2 wks. |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE - (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 16, 1949, *to* Nov. 28, 1949, *that I last saw the deceased alive on* Nov. 28, 1949 *and that death occurred at* 9:45 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 30 1949 | Family lot | Bamplin, Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Covington Williams M.D. | Holland Funeral Home | 1651 Druid Hill Ave. |

VS 150

14

Correct entries especially important; physician: please write the cause of death clearly and legibly.

G80335

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80335 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Starter (STAMPER)

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1319 E. Lombard St. 3-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | Widow | Nov 22, 1898 | 51 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Md | |

13. FATHER'S NAME: William ?

14. MOTHER'S MAIDEN NAME: Anne Bowie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Blanche Carter | 1429 E Lombard St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension & Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yr.

DUE TO

(B) Acute Pulmonary Edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Nov. 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 29/49 | Mt Calvary Cem | B. C. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | | Mrs. Robert A. Elliott | 1129 N. Carlton St. |

VS 151

93D

Please write the causes of death clearly and legibly. Physicians: please write the age is especially important.

G80336 CERTIFICATE CORRECTED 12/2/49 ✓

BALTIMORE CITY HEALTH DEPARTMENT G80536

# CERTIFICATE OF DEATH 19

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mabel Wood

2. DATE OF DEATH 11/28/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square

c. Length of stay in Baltimore 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY 1137 Light St. Md.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md.

D. STREET ADDRESS (If rural, give location) 1137 Light St. 24-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | 4/15/84 | 64 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Charles Desmead

14. MOTHER'S MAIDEN NAME Mary Montgomery

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Cancinomatosis & Chronic dehydration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Malignant Melanoma left thigh. — 2 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION Nov 47; July 48. 19B. MAJOR FINDINGS OF OPERATION Malignant melanoma left thigh Gen. metastases & regional

20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/15 1949 *to* 11/28 1949, *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* 10A m., *from the causes and on the date stated above.*

23A. SIGNATURE O. Fred Hawkins, Jr M. D. 23B. ADDRESS Franklin Square Hosp 23C. DATE SIGNED 11/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 24B. DATE 12/1/49 24C. NAME OF CEMETERY OR CREMATORY GREENMOUNT 24D. LOCATION (City, town, or county) GREENMOUNT AVE + NORTH. (State)

DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1949 REGISTRAR'S SIGNATURE Center for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS JOHN F. DENNY, INC 715 LIGHT ST

VS 150

53 -30

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680537

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

680537 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward T. Sullivan — 2. DATE OF DEATH Nov 27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hosp.
c. Length of stay in Baltimore 50 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY 310 S. Calhoun St. Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto Md.
D. STREET ADDRESS (If rural, give location) 310 S. Calhoun St 19-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug 21-1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | B & O. R. R. | Carroll Co - Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jeremiah Sullivan | Mary Carroll |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 7050-56015 | Mary Elizabeth Sullivan | 310 S. Calhoun |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L. Beyer M.D. | | 27 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 30-1949 | Springfield | Sykesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | | Ellsworth Armacost | 5118 Harford & Oak Ave |

VS 151

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80538 C80538

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 48-28508 **CERTIFICATE OF DEATH** 571.0 Registered No.

1. NAME OF DECEASED (Type or Print) James Ronald Jones — 2. DATE OF DEATH 11-28-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE md — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17
D. STREET ADDRESS (If rural, give location) 2005 Clifton Ave. 15-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

c. Length of stay in Baltimore ~~Yrs.~~ 11 ~~Mos.~~ ~~Days~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | 12-21-48 Jan 1949 | — | 11 / 7 | - / — |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child — 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md. — 12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Calvin Jones — 14. MOTHER'S MAIDEN NAME Ruth Beard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO — 17. INFORMANT Father — ADDRESS Same

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acidosis
DUE TO
(B) Dehydration
DUE TO
(C) Diarrhea

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24, 1949 *to* 11-28, 1949 *that I last saw the deceased alive on* 11-28, 1949 *and that death occurred at* 1:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE Edwin M. Hubbard M.D. — 23B. ADDRESS University Hosp. — 23C. DATE SIGNED 11-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24B. DATE Nov. 30, 1949 — 24C. NAME OF CEMETERY OR CREMATORY Govans — 24D. LOCATION (City, town, or county) (State) Cockeysville Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR Landon M. Brooks — ADDRESS Sparks, Md.

VS 150

119a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80339 ✓ G80339

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Emma Lee

2. DATE OF DEATH: II-26-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 629 North Bond Street

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City

D. STREET ADDRESS (If Rural, give location): 629 North Bond Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | 3-2-1899 | 50 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Baltimore City

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dolpes Backson

14. MOTHER'S MAIDEN NAME: Willemenia Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: Mary Lee 629 North Bond Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronaline) Heart Failure | 2 mos |
| DUE TO (B) | Arteriosclerotic) Heart Disease? | |
| DUE TO (C) | Arteriosclerosis | ? |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 9, 1949 *to* Nov 26, 1949 *that I last saw the deceased alive on* Nov. 16, 1949, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23A. SIGNATURE F. K. Quinn M. D.

23B. ADDRESS 1223 N. Coroline

23C. DATE SIGNED Nov. 28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: II-29-1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvery Cemetary

24D. LOCATION (City, town, or county) (State): Brooklyn A.A.Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949

REGISTRAR'S SIGNATURE: Courtney [illegible], M.D.

25. FUNERAL DIRECTOR ADDRESS: Elroy O. Wilson 1000 Brantly Avenue

VS 150

937

G80340

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 05

G80340 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William P. Reese (REESE)

2. DATE OF DEATH Nov. 27, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 6119 Glenoak Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6119 Glenoak Ave.
c. Length of stay in Baltimore 51 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6119 Glenoak Ave 27-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 26, 1898 | 51 | 4 / 1 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholstery Factory
10B. KIND OF BUSINESS OR INDUSTRY in Business
11. BIRTHPLACE (State or foreign country) Baltimore
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME John A. Reese
14. MOTHER'S MAIDEN NAME Mary E. Turner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. No
17. INFORMANT Mr. John J. Reese ADDRESS 1616 E. Hoffman St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
(B) Obesity
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(C) Streptococcal Sore Throat — 2 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 26, 1949 to Nov. 27, 1949 that I last saw the deceased alive on Nov. 26, 1949, and that death occurred at ... m., from the causes and on the date stated above.

23A. SIGNATURE Lewis B. Wolfe M.D.
23B. ADDRESS 133 E. North Ave
23C. DATE SIGNED 11-28-49.

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Nov. 30, 1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR NOV 29 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Elmer W. Conklin ADDRESS 924 E. Eager St

VS 150

115C

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80341 J X 581.0 G80341

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): IDA KRAFT
2. DATE OF DEATH: 11/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location): Columbia Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 1/3/1911 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles E. Boone | Bertha A. Smallwood |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | John Kraft | Same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cirrhosis of the liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/24, 1949 *to* 11/27, 1949 *that I last saw the deceased alive on* 11/27, 1949, *and that death occurred at* 7:15 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert A. Lucas M. D. | St. Agnes Hospital | 11/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Entombment | 11/30/49. | Lorraine Mausoleum | Woodlawn, Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Easton Sons | Ellicott City, Md. |

VS 15●

1240

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680342

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

680342 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Wilbur Keller

2. DATE OF DEATH: 11-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Sanatorium 600 South Chapelgate Lane

c. Length of stay in Baltimore: 27 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore
B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Lundale
D. STREET ADDRESS (If rural, give location): 6826 Belclair Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 11-25-1882
9. AGE (In years last birthday): 67 yrs (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steel Worker
10B. KIND OF BUSINESS OR INDUSTRY: Steel Works
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Robert Keller
14. MOTHER'S MAIDEN NAME: Margaret A. Seeton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs M. Keller. ADDRESS: 6826 Belclair Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Manic Depressive Psychosis — 50 yrs

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14-1949 *to* 11-28-1949, *that I last saw the deceased alive on* 11-27-1949, *and that death occurred at* 7:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Bridey, M. D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 11-28-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Nov. 30, 1949
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Roland L. Fickes, 2112 Dundalk Ave

VS 150

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680343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

680343 Registered No.

STATE FILE NO.

1. NAME OF DECEASED (Type or Print) **Mary Hall**

2. DATE OF DEATH **Nov. 27, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **1327 Upton St.**
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **1327 Upton St.** 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **Female** | **Colored** | **Widow** | | **78** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **Housewife** | | **Maryland** | **U. S. A.** |

13. FATHER'S NAME **William Powell**

14. MOTHER'S MAIDEN NAME **? Snowden**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | **Mrs Fannie Powell-405 N. Carey St.** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) **Hypertensive Cardio Vascular** | |
| DUE TO | (B) **Arteriosclerosis** | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| **None** | ✓ | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| ✓ | ✓ | ✓ |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| ✓ m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | ✓ |

22. *I hereby certify that I attended the deceased from* **8/3/** 19**48**, *to* **11-26**, 19**49** *that I last saw the deceased alive on* **11-26**, 19**49**, *and that death occurred at* **7:30** A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **C. M. Lawrence** M. D. | **1033 W. Lanvale St** | **11-29-49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **11-30-49** | **Mt. Auburn Cem** | **Baltimore, Md.** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | **M R Stearns A Hensley** 578 W Biddle St |

VS 150

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G80347 331 G80347

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frank H. James Sr.

2. DATE OF DEATH Nov. 26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4901 Cordelia Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18
D. STREET ADDRESS (If rural, give location) 4901 Cordelia Ave.

c. Length of stay in Baltimore About 56 yrs. (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 26, 1877 | 72 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Dentist | Dentist | Bedford, Pa. | U.S.A. |

13. FATHER'S NAME Henry C. James

14. MOTHER'S MAIDEN NAME Sophia E. Shaffer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs Wallace M James | 4901 Cordelia Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Cerebral Arterio-Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 25, 1949, *to* Nov. 26, 1949, *that I last saw the deceased alive on* Nov. 25 1949, *and that death occurred at* 4:35 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Julius C. Bluch, M. D. | 5356 Reisterstown Rd | 11/27/49 |

| 24. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Nov 30/49 | London Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | [illegible] for Baltimore, Md. | Loring Byers | 5005 Reisterstown Rd |

VS 150

83a

Correct age if especially important; if unknown, please write the cause of death clearly and legibly.

G80345 ✓ D G80343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 420

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE W. RIDGAWAY

2. DATE OF DEATH Nov. 28, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1116 N. Bentalou St. 16-05

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1116 N. Bentalou St.

c. Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Oct. 31, 1885 | 64 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Floor Supervisor(rtd) | Department Store | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Ridgaway | Mary Todd |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 213-09-7355 | Mrs. Julia M. Ridgaway | 1116 N. Bentalou St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) arteriosclerotic heart disease | 2 yrs. |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Pulmonary Embolism | 8 mos. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 1947 *to* Nov. 28, 1949, *that I last saw the deceased alive on* Nov. 27, 1949, *and that death occurred at* 1:15 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Morris B. Sheeter, M.D. | 5404 Fulton Ave | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/30/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93D

G80346 Siegel

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80346

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Blackwell — 50. — 2. DATE OF DEATH: Nov. 24, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Turner Station
D. STREET ADDRESS (If rural, give location): Ap't. 339 B. Finch Ct.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Married | Oct. 26, 1921 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Cameron N.C. | U.S.A. |

13. FATHER'S NAME: Henry Morrison

14. MOTHER'S MAIDEN NAME: Irene Davis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Alfred Blackwell | 339 Finch Ct. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhage and Shock — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Abortion (Self Induced)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | Md. Ap't. 339 B. Finch Ct., Turner Station |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Abt. Nov. 20, 1949 ? m. | WHILE AT WORK ☐ · NOT WHILE AT WORK ☒ | Ingestion of Watkin's Liniment containing camphor and other chemicals, also took Ergot |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. B. Fisher M.D. | | Nov. 25, 1949 |

| 24A. BURIAL, CREMATORY, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-30-1949 | W. Arbutus Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Mrs. Hattie R. Williams | 322 N. Schroeder St. |

VS 151

141 E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80347

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44 Registered No. C80347

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret A. Parker

2. DATE OF DEATH Nov. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1107 W Lexington St.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 18-0-?
D. STREET ADDRESS (If rural, give location) 1107 W. Lexington St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | Sept. 23, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Balto. Md | U.S.A. |

13. FATHER'S NAME William J King

14. MOTHER'S MAIDEN NAME Mary Ann ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Edna Parker ADDRESS 720 Pierce St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | 4-5 Days |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertension via Cardiovascular Renal disease | Unknown |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Decubitus ulcer. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 1948, to Nov 24, 1949, *that I last saw the deceased alive on* Nov 23 1949, *and that death occurred at* 4 30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Garland Quindley M.D. | 902 N. Franklin St | 11-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-29-1949 | Mt. Auburn Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Mrs. Kate R. Williams | 302 N. Monroe St. |

VS 150

131a

G80348

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80348

1. NAME OF DECEASED (Type or Print): Mrs. Catherine Marie Popp

2. DATE OF DEATH: November 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1007 Wilmot Court

5. SEX: Fe.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Sep.
8. DATE OF BIRTH: 1910
9. AGE (In years last birthday): 39 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: FRANK JOESKY
14. MOTHER'S MAIDEN NAME: KATIE McGANEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Miss Mary Joesky — ADDRESS: 3032 Barclay St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus.
DUE TO
(B) auricular fibrillation & intramural thrombosis (inactive)
DUE TO
(C) Rheumatic heart disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Post-Operative sympathectomy

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 11-17-49
19B. MAJOR FINDINGS OF OPERATION: Lumbar sympathectomy performed.
20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/30/ , 1949 *to* 11/25/ , 1949 *that I last saw the deceased alive on* 11/25/ , 1949 *, and that death occurred at* 2:00AM m., *from the causes and on the date stated above.*

23A. SIGNATURE: William D. Rodgers M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 11/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 11-28-49
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Govans
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Wiedefeld & Son
ADDRESS: 95B - Greenmount Ave & 22nd St. -

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80349

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80349
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DAVID McCourt

2. DATE OF DEATH: 11-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland St. Joseph Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2208 Cecil Avenue 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1890 | 59 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ASST TRAFFIC MGR.

10B. KIND OF BUSINESS OR INDUSTRY: LEVER BROS. -

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter J. McCourt

14. MOTHER'S MAIDEN NAME: Ellen Fahey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS: 2208 Cecil Avenue
Mrs. Catherine McCourt

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-27-, 1949 *to* 11-28, 1949 *that I last saw the deceased alive on* 11-28, 1949, *and that death occurred at* 2:45 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Kaan M. D.

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIED

24B. DATE: 12-1-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem

24D. LOCATION (City, town, or county): City (State)

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WIEDEFELD & SON

ADDRESS: GREENMOUNT AVE & 22ND

VS 150

93

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80330

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903-5

G80330 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter E. Graham N-831.0

2. DATE OF DEATH: 11/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5540 Belair Rd Sandwilla Convalescent Home

c. Length of stay in Baltimore: 55-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 15-06

D. STREET ADDRESS (If rural, give location): 3018 Walbrook Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | 11/27/1866 | 83 sml | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stone Mason | | Pa. | |

13. FATHER'S NAME: William Graham

14. MOTHER'S MAIDEN NAME: Nancy MacPherson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | none | Mrs. Lillian Frazier | 3025 Walbrook Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of left femur — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypostatic pneumonia

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☑ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Street | In front of Walbrook Theater North Ave. & Rosedale Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 10-8-49 4:15 P m. | | Fell from curb to street 15/47 |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| C. L. Pulaski M.D. | | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-2-49 | Woodlawn | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | G. Howard Strong | 3207 W. North Ave., |

VS 151

186a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80351

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80351

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Edward Owens

2. DATE OF DEATH: November 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S.Marine Hospital Baltimore 11, Md.

c. Length of stay in Baltimore: Yrs. 22 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Norfolk
D. STREET ADDRESS (If rural, give location): RFD 2, Box 494

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Widowed | Dec. 3, 1889 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Railroad Worker | Railroad | Virginia | USA |

13. FATHER'S NAME: George Owens

14. MOTHER'S MAIDEN NAME: Holdie Wilson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW 1 | - | Records-US Marine Hospital | Baltimore, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malignant melanoma right thumb with generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Nov. 4, 1949, *to* Nov. 25, 19 49 *that I last saw the deceased alive on* Nov. 25, 1949, *and that death occurred at* 7:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | U.S.Marine Hospital, Balto., Md. | 11-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | | Norfolk, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Charles R. Law | 802 Mad. Ave. |

VS 150

53

G80352

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G80352

1. NAME OF DECEASED (Type or Print): John C. Rudel, Sr.

2. DATE OF DEATH: Nov. 28-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 604 Wild Wood Pkwy 16-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | ~~Single~~ Widowed | 8-22-1870 | 79 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John
14. MOTHER'S MAIDEN NAME: Margaret Louise

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John Rudel, ADDRESS: 604 Wildwood Pkwy.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma, Liver, Metastatic — DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: ~~Chronic~~ Cholecystitis & Cholelithiasis, Ascites

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/2/49 | Carcinoma of Liver, metastatic, Cholelithiasis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 11/8, 1949, to 11/28, 1949, that I last saw the deceased alive on 11/27, 1949, and that death occurred at 8:35 A.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rafael V. Ramirez M. D. | St. Agnes Hospital | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 1/49. | New Cathedral | 4300 Old Frederick Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | Harry R. Ritzler | 4101 Edmondson Ave. |

VS 150

46F

Correct age if especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80353

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carroll C. Bagley

2. DATE OF DEATH: Nov. 27-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location): 3324 Kueckert Ave

C. Length of stay in Baltimore: Yrs. 27 Mos. 0 Days 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3324 Kueckert Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | May 25-1889 | 60 | 6 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired B.T.C. | | Harford Co. Md. | |

13. FATHER'S NAME: John O. Bagley

14. MOTHER'S MAIDEN NAME: Laura Greenland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-09-3624

17. INFORMANT: Mrs. Anna Bagley ADDRESS: 3324 Kueckert

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 16 d

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 27, 1949 *to* Nov 27, 19__, *that I last saw the deceased alive on* Nov 27, 1949, *and that death occurred at* 11:55 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: L. Emmett Queen M.D.

23B. ADDRESS: 1016 N. Read St. Balto.

23C. DATE SIGNED: Nov 28, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-30-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Luck - 5305 ADDRESS: Harford

VS 150

94a

Correct age at capacity important. Physicians: please write the causes of death clearly and legibly.

St. Mary
St. Cathedral

G80354
STATE NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 Registered No. G80335

1. NAME OF DECEASED (Type or Print): Catherine E. Evans
2. DATE OF DEATH: Nov. 27-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3523 Greenmount Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-03
D. STREET ADDRESS (If rural, give location): 3523 Greenmount Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 12-1870
9. AGE (In years last birthday): 79 — If Under 1 Year: Months 10, Days 15 — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Theodore Sondergild
14. MOTHER'S MAIDEN NAME: Louisa Kohlmann
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Edward T. Evans ADDRESS: 3523 Greenmount

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hemorrhage into brain | 2 days |
| DUE TO | | |
| ANTECEDENT CAUSES (B) | Hypertensive cardio-vascular disease | ? 3 yrs. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | Old age | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* August, 1946 *to* November 27, 1949, *that I last saw the deceased alive on* November 27, 1949 *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Minor S. Mann, M. D.
23B. ADDRESS: 516 Cathedral St.
23C. DATE SIGNED: 11/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 11-30-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
26. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford Ave.

VS 150

93D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly

G80355

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80355

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles E. Sorensen

2. DATE OF DEATH: Nov. 26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3338 Virginia Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-16
D. STREET ADDRESS (If rural, give location): 3338 Virginia Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | June 15/1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Contr. Work | Brick Layer | Denmark | "USA." |

13. FATHER'S NAME: Christian P. Sorensen

14. MOTHER'S MAIDEN NAME: Margaret-Katz.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 215-05-3969 | Minnie Sorensen | - Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) | Pulmonary Tuberculosis Bilateral with Cavitation both upper Lobes active | Dec 1, 1946 |
| DUE TO (B) | Acute Pulmonary Haemmorrhage | Nov 26, 1949 |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 1 1946, *to* Nov 26, 1949, *that I last saw the deceased alive on* Nov 26 1949, *and that death occurred at* 7:45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter E Lawson M. D. | 4043 Park Heights Ave | 11-26-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Nov-30-49 | Loudon Park | Balto - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 29 1949 | Huntington Williams, M.D. | H. B. Skippert & Son - | 130 Eutaw Pl. |

VS 150

13B

G 80356

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G 80356

1. NAME OF DECEASED (Type or Print): Alverdia F. Shewell

2. DATE OF DEATH: November 29, 1949.

3. PLACE OF DEATH:
a. Baltimore City, Maryland 353 Rosebank Ave.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore.
D. STREET ADDRESS (If rural, give location): 559 E. 38th St. 9-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married. | November 1, 1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own home. | Baltimore Co., Md. | U.S.A. |

13. FATHER'S NAME: Mortaciah Price

14. MOTHER'S MAIDEN NAME: Rachel Armacost.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | | James Shewell | 559 E 38th St. Balto. Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemmorhage | 3 days |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis | unknown |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Diabetis Mellitis | unknown |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 7th. 19 49, *to* Nov. 29th. 19 49, *that I last saw the deceased alive on* Nov. 29th. 19 49, *and that death occurred at* 1:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jack Margolies | 401 E. 25th. St. | 11/29/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | December 2 1949 | Forestor Cemetery | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12/1/49 | | Jacob Harlenstein | New Freedom, Pa. |

VS 150

61

G80357

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80357

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Agnes Tolson Armstrong

2. DATE OF DEATH: 11/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2102 Edman Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2102 Edman Ave. 9-0

5. SEX: Female
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 6/21/1878
9. AGE (In years last birthday): 71
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dr. Wm H. Tolson
14. MOTHER'S MAIDEN NAME: Annie Newell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: V. Denny Armstrong ADDRESS: 2102 Edman Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): No
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 15th 1948, *to* Nov 28th, 1949 *that I last saw the deceased alive on* Nov 27th, 1949, *and that death occurred at* 2:30 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. L. Leordy M.D.
23B. ADDRESS: 5106 Harford Rd
23C. DATE SIGNED: 11-29-49

24A. ~~BURIAL, CREMATION, REMOVAL~~ (Specify): Burial
24B. DATE: 11/30/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Green Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul st.

VS 150

937

G80358

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 80 2

G80358 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH MARTIN N-804-2

2. DATE OF DEATH: November 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~
D. STREET ADDRESS (If rural, give location): 6111 Falls Street

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 5/10/1885 | 64 | 6 | 18 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sanitation Dept

10B. KIND OF BUSINESS OR INDUSTRY: City of Balto

11. BIRTHPLACE (State or foreign country): Lincoln, Calif.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Martin

14. MOTHER'S MAIDEN NAME: Annetta (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes

(If yes, give war or dates of service): W. W. #1

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Martin ADDRESS: 6111 Falls Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, left

DUE TO

(B) Multiple rib fractures, bilateral

DUE TO

(C) Fracture, skull
Contusion, brain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Railroad Track

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Approx. 6400 Blk. Falls Road, Balto Co., Md.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-25-49 3:19 P m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by R. R. Train

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 11-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/2/49

24C. NAME OF CEMETERY OR CREMATORY: U. S. National

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jones Funeral Home ADDRESS: 1217 St. Paul St.

VS 151

169

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. [redacted]

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. [redacted]

1. NAME OF DECEASED (Type or Print): JOSEPH A. RYAN

2. DATE OF DEATH: November 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 25 S. Augusta Avenue 20-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 4/22/1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Self | Midland Md. | |

13. FATHER'S NAME: Francis P. Ryan

14. MOTHER'S MAIDEN NAME: Mary A. Carroll

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W. #1 | | Barbara T. Ryan | 25 Augusta Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic congestive heart failure

DUE TO

(B) Arteriosclerotic cardiovascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE [signature] M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 11-28-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/30/49 | U.S. National | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 127 St. Paul St.

VS 151

9-D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80360 ✓ G80360

BIRTH NO. G80360

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 33

Registered No.

1. NAME OF DECEASED (Type or Print): EMMA RUPP BARNHART

2. DATE OF DEATH: Nov. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3408 Edgewood Rd.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3408 Edgewood Rd. 15-11

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 27, 1873
9. AGE (In years last birthday): 76 yrs. (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): -
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rev. Wm. Rupp
14. MOTHER'S MAIDEN NAME: Emma Hambright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rev. John L. Barnhart ADDRESS: 3408 Edgewood Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) (Repeated) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs -

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — Indefinite

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1948 *to* Nov, 1949 *that I last saw the deceased alive on* 27 Nov, 1949, *and that death occurred at* 2 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 2020 N Charles St
23C. DATE SIGNED: 29 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 11/30/49
24C. NAME OF CEMETERY OR CREMATORY: Union Cem.
24D. LOCATION (City, town, or county) (State): Greensburg, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

83C

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80361 G80361

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 350

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): DR. CHARLES K. SWARTZ
2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2601 Lyndhurst Ave.
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2601 Lyndhurst Ave. 15-09

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Jan. 3, 1861
9. AGE (In years last birthday): 88 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): professor of Geology
10B. KIND OF BUSINESS OR INDUSTRY: University
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joel Swartz
14. MOTHER'S MAIDEN NAME: Adelia Rosecrans
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mr. Joel H. Swartz ADDRESS: 2601 Lyndhurst Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Parkinson's Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Myocarditis

DUE TO

(C) Prostatic Hypertrophy

Uraemia

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 23, 1949, *to* Nov 27, 1949, *that I last saw the deceased alive on* Nov 27, 1949, *and that death occurred at* 1 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Abram Freud M. D.
23B. ADDRESS: #316 Medical Arts Bldg.
23C. DATE SIGNED: Nov 29 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/1/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem.
24D. LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Richard Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

NOV 30 1949

93D

G80362

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80362 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob G. Rosenheim

2. DATE OF DEATH: 11-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. General Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 520 N. Pulaski St. 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Aug. 24, 1871 | 78 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | Alma Mfg. Co. | Balto. Md. | |

13. FATHER'S NAME: Gustav Rosenheim

14. MOTHER'S MAIDEN NAME: Betsy Frank

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 220-07-9072 | Mrs. Fannye K. Rosenheim | 520 N. Pulaski St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema.

DUE TO

(B) Acute myocardial infarction.

DUE TO

(C) Chronic obstructive coronary disease. Dorsal kypho-scholiosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 25, 1949, *to* November 28, 1949, *that I last saw the deceased alive on* Nov 28, 1949, *and that death occurred at* 8:55 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Teicher M.D. | 1101 Baltimore Med. Bldg. | 11-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11/30/49 | Hebrew Friendship Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80363 G80363

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs Lillie Charlotte Albrecht

2. DATE OF DEATH: 11-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospt.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balt. Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D. STREET ADDRESS (If rural, give location): 18 N. Pulaski St. 21-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | Aug. 25, 1876 | 73 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Nils Sahlin | Charlotte |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | no | Mr. Wm. G. Albrecht, Jr. 211-213 S. Sharp St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho-pneumonia.

DUE TO

(B) Bulbar palsy Edema.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertension C.V.D.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebro-vascular accident.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/7, 1949 *to* 11/28, 1949 *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* 10:10 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. Schaefer M.D. | Bon Secours Hosp. | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | Western Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| | | WM. J. TICKNER & SONS Balto., Md. |

VS 150

937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80364

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 178

G80364 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RICHARD M. LINDEMON, SR.

2. DATE OF DEATH: Nov 28, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3607 Malden Ave
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3607 Malden Ave. 12-06

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 22 1927
9. AGE (in years last birthday): 22 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Helper
10B. KIND OF BUSINESS OR INDUSTRY: Beth Steel Co
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert F. Lindemon
14. MOTHER'S MAIDEN NAME: Lula V. Meadows.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Geneva I. Lindeman ADDRESS: 3607 Malden Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Teratoma - testicle (testicle) DUE TO
(B) Metastasis. DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 12, 1949 to Nov 28, 1949, that I last saw the deceased alive on 11-25, 1949, and that death occurred at 10 1/2 m., from the causes and on the date stated above.

23A. SIGNATURE: Raymond J. Lemmon M.D.
23B. ADDRESS: 326 Dally Rd
23C. DATE SIGNED: 11-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 1/49
24C. NAME OF CEMETERY OR CREMATORY: Woodlawn
24D. LOCATION (City, town, or county) (State): Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Lenten E. Donovan ADDRESS: 3818 Poland Ave

VS 150

51C

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80365 Registered No.

1. NAME OF DECEASED (Type or Print): Hyeth Penn Johnson

2. DATE OF DEATH: 11/28/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bar-Wil-Ba-Institution
c. Length of stay in Baltimore: Life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-03
D. STREET ADDRESS (If rural, give location): 231 N. Bible St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Widowed | Oct. 10, 1879 | 70 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Expressman (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: Own Business
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Owen S. Johnson
14. MOTHER'S MAIDEN NAME: Bessie —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Bar-Wil-Ba-Supt. ADDRESS: 1317 Pulaski Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Caries Renal Disease
DUE TO
ANTECEDENT CAUSES
(B) Hyperpiesia
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 1 year; (B); (C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/11, 1949, *to* 11/28, 1949 *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* 4:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: M. L. Lassiter M.D.
23B. ADDRESS: 600 N. Arlington Ave.
23C. DATE SIGNED: 11/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 11/30/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county): Balto. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR: Nov 30 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Jokett L. Young ADDRESS: 1532 E. Monument St.

VS 150

131a

G80366

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 364

G80366

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Julia Siemer

2. DATE OF DEATH: 11/29/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland Balto. Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 1345 Richardson Street 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 11/17/16 | 33 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md | |

13. FATHER'S NAME: John Schier

14. MOTHER'S MAIDEN NAME: Marion Herrman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bulbar palsy

DUE TO Polyneuritis, etiology unknown

(B) Diphtheria

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/26/49, 19__, *to* 11/29/49, 19__, *that I last saw the deceased alive on* 11/29/49, 19__, *and that death occurred at* 12 Noon *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Wm. B. Yaeger, M. D. | 1213 Light St. | 11/29/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Holy Cross Cem | A. A. Co Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Eunice Williams | Charles F. Dill | 150 E. Fort Ave |

VS 150

87B

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

G80367

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80367

Registered No.

1. NAME OF DECEASED (Type or Print): HENRY C STERN

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3917 Boarman Ave
C. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-10
D. STREET ADDRESS (If rural, give location): 3917 Boarman Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Drug | Germany | |

13. FATHER'S NAME: Carl

14. MOTHER'S MAIDEN NAME: Dora

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Charlotte Stern | 3917 Boarman |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the stomach & metastases — INTERVAL BETWEEN ONSET AND DEATH: about 3½ mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/2/49 *to* 11/29, 19 49 *that I last saw the deceased alive on* 11/29, 19 49, *and that death occurred at* 3:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edwin Lougar, M. D. | 912 Broom Lane | 11/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-30-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Assistant for Williams, Mell | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

46 R

G80368

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80368

BIRTH NO. 193 Registered No.

1. NAME OF DECEASED (Type or Print): Francis John Marciano

2. DATE OF DEATH: 11/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4206 Euclid Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4206 Euclid Ave 28 4

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | 12-21-37 | 11/12 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ft. Pitt. Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Marciano
14. MOTHER'S MAIDEN NAME: Tina Tavano

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: John Marciano ADDRESS: 4206 Euclid Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain Tumor
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 mo

19A. DATE OF OPERATION: 2 Sept 49 a. Sept 49
19B. MAJOR FINDINGS OF OPERATION: Brain Tumor, malignant.
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 9 1949 to 28 Nov 49, that I last saw the deceased alive on 27 Nov 49 and that death occurred at 8 45 am m., from the causes and on the date stated above.

23A. SIGNATURE: Reuben B. Thomas M.D.
23B. ADDRESS: 4207 Freeland Ave
23C. DATE SIGNED: 29 Nov 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 1-1949
24C. NAME OF CEMETERY OR CREMATORY: New cemetery
24D. LOCATION (City, town, or county) (State): [illegible] Rd. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949
REGISTRAR'S SIGNATURE: Timothy F. Williams, M.D.
25. FUNERAL DIRECTOR: [illegible] ADDRESS: 2013 Greenmount Ave

VS 150

54 B

MS—128067 G80369

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

47r G80369 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Joyce

2. DATE OF DEATH 11-28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 55 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 546 Mosher St. 14-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Widowed | Aug. 31 1890 | 59 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Moses Joyce
14. MOTHER'S MAIDEN NAME Catherine Addison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Baltimore City Hospitals Records--4940 Eastern Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia
DUE TO
(B) Arteriolar nephrosclerosis
DUE TO
(C) Hypertensive cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-7- , 1949, *to* 11-28- , 1949, *that I last saw the deceased alive on* 11-28- 1949, *and that death occurred at* 5:25 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED 11-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-2-49
24C. NAME OF CEMETERY OR CREMATORY St Peters Cem.
24D. LOCATION (City, town, or county) (State) md

DATE RECEIVED BY LOCAL REGISTRAR NOV 30 1949
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR George G. Kilson ADDRESS 1303 Pennsylvania Ave

VS 150

131a

G80370

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80370 Registered No.

BIRTH NO. 49-26078

1. NAME OF DECEASED (Type or Print): Baby Boy BELZ

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSPITAL

c. Length of stay in Baltimore: 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2602 HAMPDEN AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | S | NOV 26-1949 | | | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | — | BALTIMORE, MD | USA |

13. FATHER'S NAME: FERDINAND BELZ

14. MOTHER'S MAIDEN NAME: BERNICE E

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | — | FERDINAND BELZ | 2602 HAMPDEN AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CONGENITAL HEART DISEASE TETRALOGY of FALLOT

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* NOV 26, 1949 *to* NOV 29, 1949 *that I last saw the deceased alive on* NOV 29, 1949, *and that death occurred at* 12:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter C. Friedman M. D. | Hopkins Hospital | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | NOV 30 1949 | NEW CATHEDRAL | BALTIMORE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Lemuel Williams, M.D. | Chas J Ecker & Son Inc | 118 N Mt Royal Ave 157E |

VS 150

BIRTH NO. G80371

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80371

E-812.7 N-891.2

1. NAME OF DECEASED (Type or Print): LOUISE GOODSON

2. DATE OF DEATH: November 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 944 Mason Street 11-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | July 8 1942 | 7 years | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| unemployed | | S. C. | U. S. A. |

13. FATHER'S NAME: Thomas Alebourn

14. MOTHER'S MAIDEN NAME: Ada Louise ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ada Goodson - 944 Mason St.

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Asphyxia | |
| DUE TO | Vinethane anesthesia | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | (over) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Auto Accident Repair<br>Skin graft operation | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Hospital

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Baltimore City Hospital

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-28-49 A. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Patient died on operating table under ~~Vinethane anesthesia~~

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Earl L Ruge M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 11-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Shipped

24B. DATE: 12-3-49

24C. NAME OF CEMETERY OR CREMATORY: Raleigh N.C.

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949

REGISTRAR'S SIGNATURE: Curtis for Williams, MD

25. FUNERAL DIRECTOR: A. Halstead

ADDRESS: 918 Lloyd 170 c Hill Ave.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80372

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80372 Registered No. 490

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SAMUEL FINNEY

2. DATE OF DEATH: 11/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1605 ARGYLE AVE
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO 17-07
D. STREET ADDRESS (If rural, give location): 1605 ARGYLE AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | C. | MARRIED | 12/2/98 | 50 | 11 | 15 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LABORER | | RICHMOND VA. | U.S.A. |

13. FATHER'S NAME: CHAS FINNEY

14. MOTHER'S MAIDEN NAME: POLY ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | MRS SAMUEL FINNEY | 1605 ARYLE AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) LOBAR PNEUMONIA — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) OBESITY — DUE TO — UNKNOWN

(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* NOV. 26 19 49 *to* NOV 27 19 49 *that I last saw the deceased alive on* NOV 26 19 49 *and that death occurred at* 10:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Fray M.D. | 921 Penna Ave | 11/29/49 |

| 24A. BURIAL? CREMATION? REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, or other county) (State) |
|---|---|---|---|
| Burial | 12-1-49 | Mt Calvary | Cedar Hill Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Thornton Williams, M.D. | W. Halstead - 918 - 108 Druid Hill Ave | |

VS 150

G80373

G80373

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Leeds

2. DATE OF DEATH: November 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Fla.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Deland
D. STREET ADDRESS (If rural, give location): 1650 South Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Child | 2-4-49 | | 10 | 25 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fla.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Leeds

14. MOTHER'S MAIDEN NAME: Georgeanne Mander.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hypotension — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO

(B) Arachnoid cysts, anatomical cong. hydrocephalus — 10 days.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 11/19/49 11/29/49

19B. MAJOR FINDINGS OF OPERATION: Hydrocephalus.

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-10 1949 *to* 11-29 1949, *that I last saw the deceased alive on* 11-29 1949, *and that death occurred at* 10:3 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert G Fisher M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 11/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 11-30-49

24C. NAME OF CEMETERY OR CREMATORY: Lexington

24D. LOCATION (City, town, or county) (State): Ky.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Charles P Towell

ADDRESS: 1570 2427 Eutaw Place

VS 150

BIRTH NO. G80374

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 8 12.4 G80374
N-108

Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT (ELLIS) LaNEHART (dja)

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Yrs. n Mos. Life Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4903 York Road 27-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | single | 8- 1896 | 53 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): sexton
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Lanehart
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 215-22-2709
17. INFORMANT: personal cards ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed chest
DUE TO
Fractured pelvis
Fractured legs
(B) Subarachnoid hemorrhage.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): York Road & Radnor Avenue 27/10
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-25-49 10:00 P m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-30-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR ADDRESS: H.W.Jenkins&Sons Co.4905York Rd.

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170c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 450 · 9

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dennis L. Manning. | 2. DATE OF DEATH: Nov 28th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland: Maryland. | B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 808 Gounod Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: 3734 Old York Road 9-01 | B. COUNTY | c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland. | D. STREET ADDRESS (If rural, give location): 808 Gounod Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Aug 3 1870 | 79. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Gas & Electric Co. | Balto Md | U S A |

13. FATHER'S NAME: T. Manning

14. MOTHER'S MAIDEN NAME: Ellen Sullivan.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | No | Estella T Manning | 3734 Old York Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) General Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Old age

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-25-49 19 *to* 11-28-49 19, *that I last saw the deceased alive on* 11 28 49, *and that death occurred at* 945P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Anthony F. Carozza M. D. | 5217 York Rd. | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 1 1949 | New Cathedral | Old Frederick Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Huntington Williams, M.D. | John C Moran | 3000 E Baltimore St |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATHERINE BORTNER

2. DATE OF DEATH: Nov. 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 112 S. EAST AVE

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 112 S. EAST AVE 26-10

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | M | MARCH 28 1870 | 79 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | — | MARYLAND | U. S. A. |

13. FATHER'S NAME: JOhn Long

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | KATH. ELIZ BORTNER (STEP DAUGHTER) | SAME ADDRESS |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | HYPERTENSIVE CARDIO-VASCULAR DISEASE | UNKNOWN |
| DUE TO | | |
| (B) | GENERALIZED ARTERIOSCLEROSIS | |
| DUE TO | | |
| (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* JAN. 1 1949 *to* Nov. 28, 1949, *that I last saw the deceased alive on* Nov 28, 1949 *and that death occurred at* 10 25 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry J. Houska M. D. | 333 S. EAST AVE | Nov. 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | Oak Lawn | 7225 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Huntington Williams, M.D. | Clarence F. Hoffmann | 1639 Broadway. |

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G30377 BALTIMORE CITY HEALTH DEPARTMENT 1949 G80377

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Albert H. Hill

2. DATE OF DEATH: 25 Nov 49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md. Gen'l Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland Gen'l Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Bristol outside
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bristol
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | MARRIED | JAN 25, 1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| FARMER. | | MARYLAND | U.S.A. |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | — | Ada Hill | North Beach, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 11/22 - 11/25
DUE TO
(B) RETROPERITONEAL LIPOSARCOMA
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July '49 | Retroperitoneal Liposarcoma. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/22, 1949 *to* 11/25, 1949 *that I last saw the deceased alive on* 11/25, 1949, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lowell C. Cressons M. D. | Md. Gen'l Hosp | 11/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 11-28-49 | Mt. Zion | Lothian, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 11-26 | RW - (by Mr Fahrman, State House 7) | Ritchie Bros - Upper Marlboro Md | |

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NOV 30 1949

Remington Box Williams, Md

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 151 Registered No.

1. NAME OF DECEASED (Type or Print) John W. Willard

2. DATE OF DEATH 11-29-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6005 Chapel Road Pinecrest Sanitorium Balt. Md.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 24-04
D. STREET ADDRESS (If rural, give location) 1733 William Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 3-4 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | Engineer | Virginia | U.S.A. |

13. FATHER'S NAME John Willard

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mrs Willard- |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO CANCER OF The Stomach [TYPE UNCERTAIN] & METASTESES to BACK (SPINAL muscles) — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) Ulcers of Stomach (operated) — 8 years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Bronchopneumonia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/29, 1948 *to* 11-29-, 1949, *that I last saw the deceased alive on* 11-28, 1949, *and that death occurred at* 2:05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M.D. | 2030 W. Fayette St | 11-29-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-2-49 | Glen Haven | Glen Burnie |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Dennis L. McCarthy | 130 E. Fort Ave. 46B |

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BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

C80379

Registered No.

1. NAME OF DECEASED (Type or Print): MRS. MINERVA M. YOST

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hosp.

c. Length of stay in Baltimore: 14 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 17
D. STREET ADDRESS (If rural, give location): 2025 Eutaw Place 14-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | ~~May 14 1874~~ June 25 1874 | 75. | 6 / 15 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housework | — | Hagerstown, Md. | USA. |

13. FATHER'S NAME: Charles S. Schnebeck

14. MOTHER'S MAIDEN NAME: Annie Barnes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Julia Eutaw Nelson | 2025 Eutaw Place |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular catastrophe — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive cardiovascular disease

DUE TO

(C) Hemiplegia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-17 19 49 *to* 11-29 19 49 *that I last saw the deceased alive on* 11-29 19 49 *and that death occurred at* 12 ~~PM~~ AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Carlos Acosta, M. D. | St. Joseph's Hosp. | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 1/49 | St. Paul's Cem. Kingsley | near Hagerstown Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Thomas Williams M.D. | John D. Mitchell & Son | 1100 Eutaw Place |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 44

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laura Cross

2. DATE OF DEATH November 29 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-03
D. STREET ADDRESS (If rural, give location) 218 N. Mountford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | colored | Widowed | 9-3-81 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Maryland | U.S.A. |

13. FATHER'S NAME William H. Gross

14. MOTHER'S MAIDEN NAME Anna Hammond

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | | | William H. Gross | 218 N. Mountford Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) H [illegible]

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-25 1949 *to* 11-28 1949, *that I last saw the deceased alive on* 11-28 1949, *and that death occurred at* 10 [illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Adams M. D. | JOHNS HOPKINS HOSPITAL | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-2-49 | Mt. Calvary Cem. | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR, ADDRESS |
|---|---|---|
| NOV 30 1949 | [illegible] for Williams, M.D. | Elroy O. Wilson 1000 Bentalou ave |

6

131a

MS--133783 680381 ✓ 680381

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4700 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Richard Seeney

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balty city

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore ~~1 Yr~~ 2 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 229 Spring Ct. Zone 31 X 5-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Widowed | 10-19-1877 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handy man
10B. KIND OF BUSINESS OR INDUSTRY: Gen. Store
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Seeney
14. MOTHER'S MAIDEN NAME: Julia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records--4940 Eastern Ave. ADDRESS: Baltimore City Hospitals

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertensive arteriosclerotic heart disease | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-28- , 1949, *to* 11-29- , 1949 *that I last saw the deceased alive on* 11-29- , 1949, *and that death occurred at* 11:35 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: C. J. Rogers M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 11-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-3-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: NOV 30 1949
REGISTRAR'S SIGNATURE: Signature for Williams, M.D.
25. FUNERAL DIRECTOR: Elroy D. Wilson
ADDRESS: 1000 Brantley Rd

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G80382 ✓ G80382

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 43-21055 — Registered No. 57 1.0

1. NAME OF DECEASED (Type or Print): Joyce V. Johnson — 2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 21-01
D. STREET ADDRESS (If rural, give location): 808 S. Fremont Ave.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | C | Single | Sept 1949 | — | 2 | - | - | - |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Child | | Balto, Md. | USA |

13. FATHER'S NAME: William Smith
14. MOTHER'S MAIDEN NAME: Dorothy Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mother | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Acidosis
DUE TO
(B) Dehydration
DUE TO
(C) Diarrhea, infectious

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-28, 1949 *to* 11-29, 1949, *that I last saw the deceased alive on* 11-28, 1949, *and that death occurred at* 4:00 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edwin M. Hubbard M. D. | Univ Hosp. | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-2-49 | Mt Calvery Cem | Brooklyn B.C. Co, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | Huntington Williams, M.D. | Chas. O. Wilson | 1000 Bentley rd |

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BIRTH NO. G80383

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80383

1. NAME OF DECEASED (Type or Print): Moore, Miss Margaret

2. DATE OF DEATH: Nov. 29. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home For Incurables - 700 W. 40th St.

c. Length of stay in Baltimore: 30 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 700 W. 40th St. 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | July 9, 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Practical Nurse | | Harford County, Maryland | U.S.A. |

13. FATHER'S NAME: Patrick H. Moore

14. MOTHER'S MAIDEN NAME: Mary Wallace

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | none | C. Eltermann - Home For Incurables' Records. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 45 Minutes

DUE TO

(B) Coronary Occlusion — 2 years

DUE TO

(C) arteriosclerosis — 6 years

DUE TO

(D) Senile Osteoporosis — 3 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | Home | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 10/17, 1949, *to* 11/29, 1949, *that I last saw the deceased alive on* 11/29, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Grafton Hargrove, M. D. | 214 Medical Arts Bldg. | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/2/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| NOV 30 1949 | Registrar for Williamsburg, Md. | WM. J. TICKNER & SONS Balto., Md. |

VS 150

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94a

G80384

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80384 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWIN C. IRELAN

2. DATE OF DEATH: Nov. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4300 Roland Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4300 Roland Ave. 27-14

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 21, 1875 | 74 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? retired | Md. Casualty Co. | Baltimore, Md. | |

13. FATHER'S NAME: George Irelan

14. MOTHER'S MAIDEN NAME: Margaret Achey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 212-01-1152 | Mrs. Clara N. Irelan | 4300 Roland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 11/28/49
DUE TO
(B) arteriosclerosis — —
DUE TO
(C) Hypertension — Cardio-Vascular Renal

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Nov 2 19 49, *to* Nov 28 19 49, *that I last saw the deceased alive on* Nov 22 19 49, *and that death occurred at* 4 a.m. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis F. Krumein M. D. | 722 W. Lenwood Ave | 11/29/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | Druid Ridge Cem. | Pikesville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| NOV 30 1949 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

Running for Maryland

131a

G80385

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

G80385

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDNA L. MADERT

2. DATE OF DEATH: Nov.30,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 210 E. Lafayette Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 210 East Lafayette Ave. 12-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Oct.21,1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md. | |

13. FATHER'S NAME: Levy Thompson

14. MOTHER'S MAIDEN NAME: Hattie P. Barreckman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Catherine Gavin | 210 E. Lafayette Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 mos -

DUE TO with generalized metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Aug 1949 | Biopsy = Carcinoma Stomach | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Nov, 1949 *that I last saw the deceased alive on* 29 Nov 1949 *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 2020 N Charles St | 30 Nov 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 1949 | [signature] for Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

DEC 1 - 1949

VS 150

463

G80386

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80386

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Vogel

2. DATE OF DEATH: 11/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Magothy Beach P.O.
D. STREET ADDRESS (If rural, give location): Rural

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 10/16/1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Manager

10B. KIND OF BUSINESS OR INDUSTRY: Downtown Garage

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Vogel

14. MOTHER'S MAIDEN NAME: Emalia Lehman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or Unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 230-44-8249

17. INFORMANT: Alverta Vogel ADDRESS: Magothy Beach, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Heart failure

DUE TO

(B) Status Asthmaticus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/26, 1949 *to* 11/29, 1949 *that I last saw the deceased alive on* 11/29, 1949 *and that death occurred at* 10:05 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robert J. Levickas M. D.

23B. ADDRESS: St Agnes Hospital

23C. DATE SIGNED: 11/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/2/49

24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24D. LOCATION (City, town, or county) (State): Eastern Ave Extended

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. Cook Inc. per Gus Bacon Jr.

ADDRESS: 1217 E. Pratt St

VS 150

112

G80387

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80387 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET E. GUYTON

2. DATE OF DEATH Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marley Park
D. STREET ADDRESS (If rural, give location) 128 Hollow Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year Months | Days | If under 24 hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | 4/8/13 | 36 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ~~James Guyton~~ E.M. WILKENS

14. MOTHER'S MAIDEN NAME Mary Mc Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-03-0505

17. INFORMANT Records- US Marine Hospital, Balto, Md. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Postoperative state enterostomy of ileum for intestinal obstruction, complicated by peritoneal abscesses.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) A-Embolism, pulmonary secondary to thrombophlebitis, left femoral vein

DUE TO

(C) B-Postoperative state enterostomy of ileum for intestinal obstruction, complicated by peritoneal abscesses

(over)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 wks.

19A. DATE OF OPERATION 10-24-49 11-21-49

19B. MAJOR FINDINGS OF OPERATION Repair of cystocele; uterine suspension Closure of ileostomy

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 17, 1949, *to* Nov. 29, 1949, *that I last saw the deceased alive on* Nov. 29 1949, *and that death occurred at* 11:50P m., *from the causes and on the date stated above.*

23A. SIGNATURE, M.D. Norman Tarr, Assistant Surgeon

23B. ADDRESS US Marine Hospital, Balto, Md.

23C. DATE SIGNED 11/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/3/49

24C. NAME OF CEMETERY OR CREMATORY Balto

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 1 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 150

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G80388

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

55 Registered No. G80388

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EMILIE SCHWENKE

2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3525 Caton Ave.
c. Length of stay in Baltimore: 2 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3525 Caton Ave. 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Mar, 8, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Germany | |

13. FATHER'S NAME: Karl Kummer

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Paul Schwenke | Brooklyn, N. Y. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Embolism | 12 hrs. |
| DUE TO (B) | Cardio-Vascular Renal dis. | 2 yrs? |
| DUE TO (C) | Carcinoma of Gall bladder | 1 yr? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 5-14, 19 49, *to* 11-29, 19 49, *that I last saw the deceased alive on* 11-29, 19 49 *and that death occurred at* 7:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. E. Uttan M. D. | 805 Jrd. Nat. Bk. Bldg. MD | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

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MS 133816

G80389

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 3 2

Registered No. G80389

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clara Jones

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4700 Harford Rd. 27-0

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: ? ? ?
9. AGE (In years last birthday): 72 — If under 1 year: Months / Days — If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? ?
14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Records--Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Uremia | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Miltiple Pressure Sores | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-29- , 19 49 *to* 11-29- , 19 49 *that I last saw the deceased alive on* 11-29- 19 49 *and that death occurred at* 11:45 AM *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 11-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: 1 Dec 1949
24C. NAME OF CEMETERY OR CREMATORY: Fremont Cemetery
24D. LOCATION (City, town, or county) (State): Fremont Ave. Balto.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Walter Burke Bradley, Dundalk ADDRESS:

VS 150

TO BE APPROVED BY CHIEF MEDICAL EXAMINER

836

G80390

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153 G80390 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROSE HORVITZ

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4005 Spruce Drive
c. Length of stay in Baltimore: 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 4005 Spruce Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | New York N-Y | |

13. FATHER'S NAME: Joseph Solomon

14. MOTHER'S MAIDEN NAME: Rifka

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Sam Horvitz | 4005 Spruce Dr |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Liver | 19 months |
| DUE TO (B) | Carcinoma of Bowel | 3 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 2 19 49 *to* Nov 29, 19 49 *that I last saw the deceased alive on* Nov 29, 19 49, *and that death occurred at* 3:30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2400 Eutaw Place | Nov 30 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12-1-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

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G80391

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80391

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MICHAEL FACTERWITZ

2. DATE OF DEATH: NOV. 30, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST BALTO. GEN. HOSPITAL
c. Length of stay in Baltimore: 56 Yrs. [illegible] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13
D. STREET ADDRESS (If rural, give location): 2318 Bryant Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH:
9. AGE (In years last birthday): 66
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant
10B. KIND OF BUSINESS OR INDUSTRY: Race Track
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Meyer
14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Rebecca Walters ADDRESS: 2318 Bryant Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ACUTE MYOCARDIAL INFARCTION
DUE TO
(B) HYPERTENSIVE ARTERIOSCLEROTIC CVD
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Late latent syphilis

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/10, 1949, to 11/29, 1949, *that I last saw the deceased alive on* 11/29, 1949, *and that death occurred at* 2:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: I. Goldenbel M. D.
23B. ADDRESS: W 36 A
23C. DATE SIGNED: 12/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-1-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt Carmel
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

309

G80392

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80392

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH KOUENS

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3108 REIST. RD
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 3108 REIST. RD 15-C

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WORK | | RUSSIA | U.S.A. |

13. FATHER'S NAME: NOT KNOWN

14. MOTHER'S MAIDEN NAME: ETHEL KERNER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | ABRAHAM KOUENS | 3108 REIST RD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary insufficiency

DUE TO

(B) Arteriosclerotic Coronary Sclerosis

DUE TO

(C) Acute Myocardial Infarct

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/23 19 49 *to* 11/30/49, *that I last saw the deceased alive on* 11/30, 19 49, *and that death occurred at* 9:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. L. Hamilton M. D. | 204 E. Biddle St | 11/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-1-49 | Windsor Mill Rd | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | Jack Sens Inc | 2100 Eutaw Pl. |

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RTIFICATE CORRECTED 12-5-49

G80393

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 890.0

Registered No. G80393

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY C. BUHL N-968.0

2. DATE OF DEATH Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 651 W. Lexington St. 4-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | Dec. 11 1887 | 61 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lecture Usher

10B. KIND OF BUSINESS OR INDUSTRY Fundraising

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? ✓

13. FATHER'S NAME Henry T. Buhl

14. MOTHER'S MAIDEN NAME Geraldine Turnbull

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) W. W. #1

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Lillian Buhl, 3012 W. Belvedere Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Room #12 651 W. Lexington St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 29, 1949 ? A.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? gas heater on but unlit Illuminating gas

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒.*

23A. SIGNATURE M. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Nov. 29, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | U.S. National | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | Wm. Fok Inc. | 1217 St. Paul St. |

VS 151

178a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80394 X ✓ 60.0 G80394

BIRTH NO. 49-25980

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Farrell

2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Maryland Baltimore 17, Md.

C. Length of stay in Baltimore: one ~~Years~~ ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arbutus - 29
D. STREET ADDRESS (If rural, give location): 4423 Alan Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Nov. 29, 1949 | | | 3 / 13 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Hosp. for Women of Md. Baltimore, Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Edward Farrell | Jean Murray Farrell |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Jean Murray Farrell | Arbutus 29 Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Anopenia | From birth |
| DUE TO (B) | Atalectasis, bilat. | " |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Cerebral concussion & precipitate labor | " |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cleidocranial dysostosis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 29, 1949 *to* Nov. 29, 1949, *that I last saw the deceased alive on* Nov. 29, 1949, *and that death occurred at* 4:20 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Spencer, D.M.D. | Hosp. for Women of Md. | Nov. 30, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-1-49 | St. Peters | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | George A. Farley, | Fulton and Fayette St |

VS 150

160a

Hospital Disposal

G80395 — BALTIMORE CITY HEALTH DEPARTMENT — 76 — G80395

BIRTH NO. 49-26054 — CERTIFICATE OF DEATH — Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | Baby Boy Fisher A-74476 |
| 2. DATE OF DEATH | NOV 25 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | JOHNS HOPKINS HOSPITAL |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| c. Length of stay in Baltimore — Yrs. Mos. Days | |
| D. STREET ADDRESS (If rural, give location) | 6525 Detroit Ave. 26-06 |
| 5. SEX | male |
| 6. COLOR OR RACE | White |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | |
| 8. DATE OF BIRTH | 11-22-49 |
| 9. AGE (In years last birthday) / If under 1 year: Months / Days / If under 24 hours: Hours / Min. | / 3 / 5 2 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | — |
| 10B. KIND OF BUSINESS OR INDUSTRY | — |
| 11. BIRTHPLACE (State or foreign country) | Md. |
| 12 CITIZEN OF WHAT COUNTRY? | — |
| 13. FATHER'S NAME | Melvin Fisher |
| 14. MOTHER'S MAIDEN NAME | Anna Landstrom |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO | |
| 17. INFORMANT / ADDRESS | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 11-23- , 1949 *to* 11-26- , 1949 *that I last saw the deceased alive on* 11-25- , 1949 *and that death occurred at* 12 30 A. *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | Jos. Berger M. D. | 23B. ADDRESS: JOHNS HOPKINS HOSPITAL |
| 23C. DATE SIGNED | | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: Hosp Disposal |
| 24D. LOCATION (City, town, or county) (State) | | |
| DATE RECEIVED BY LOCAL REGISTRAR | DEC 1 - 1949 | REGISTRAR'S SIGNATURE: Lindsay Lee Williams, M.D. |
| 25. FUNERAL DIRECTOR / ADDRESS | | |

VS 150

159

G80396 X ✓ 752 G80396

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-25110 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Diegert
2. DATE OF DEATH: November 19, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital
c. Length of stay in Baltimore: 0 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Joppa
D. STREET ADDRESS (If rural, give location): P.O. Fullerton
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: November 19, 1949
9. AGE (In years last birthday): If under 1 year: Months Days; If under 24 hours: Hours Min. 45
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Raymond Diegert
14. MOTHER'S MAIDEN NAME: Margaret Zealor
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: The Johns Hopkins Hospital ADDRESS: 601 N. Broadway

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hydrocephalus | 45 min. |
| DUE TO (B) | Multiple congenital abnormalities | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Fetal weight 2245 grams | |

19A. DATE OF OPERATION: No operation
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [x] NO [ ]
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): No injury
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 19, 1949 *to* Nov. 19, 1949, *that I last saw the deceased alive on* Nov. 19, 1949, *and that death occurred at* 11:15A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Andrews M.D.
23B. ADDRESS: 601 N. Broadway
23C. DATE SIGNED: 11-22-49
24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State):
DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

157a

G80397 VS 133618

BALTIMORE CITY HEALTH DEPARTMENT 176 G80397

# CERTIFICATE OF DEATH

BIRTH NO. 49-25493 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Cox- Betty

2. DATE OF DEATH: 11-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-01
D. STREET ADDRESS (If rural, give location): Victoria Hotel (Balto. & Gay Sts.)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Nov. 20 1949 | | | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Betty Cox

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Records B.C.H. | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11- 20-, 1949 *to* 11- 21-, 19__, *that I last saw the deceased alive on* 11- 21 1949, *and that death occurred at* 1.47PM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | B.C.H. 4940 Eastern Ave | 11-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 9.00AM 11-24-49 | B.C.H. Crematory | 4940 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Christine Williams, MD | | |

VS 150

159

G80398

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4201 Registered No. G80398

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SADORE FREED

2. DATE OF DEATH 11/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN HOSP.

c. Length of stay in Baltimore 48 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3817 Beehler Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Press Dress Co. | Latvia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Freed | Fannie ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Dina Freed | 3817 Beehler Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ACUTE HEART FAILURE

DUE TO

(C) ~~OL~~

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. OLD MYOCARDIAL INFARCTION

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/21/49 *to* 11/30/49, *that I last saw the deceased alive on* 11/30/49, *and that death occurred at* 11:10P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leo Lombeck M. D. | W13 & St | 11/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/1/49 | Sodova Cong. Cemetery | Herring Run, Bowleys Lane |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 1 - 1949 | Minnie Jean Williams, M.D. | Levinson Bros. 1124 W. North Ave. |

VS 150

94a

G80399 ✓ G80399

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Alexander Kaszuba

2. DATE OF DEATH: Nov 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St. 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | M. | July 16, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Antonia Kaszuba | Mary Jesukiewich |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Sister Ignatius ADDRESS 1200 Valley St. |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Edema Lungs | 1 day. |
| DUE TO | | |
| (B) | Chronic Myocarditis | 4 yrs |
| DUE TO | | |
| (C) | Arteio Sclerosis | 6 yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 1 *, 1949, to* Nov 29 *, 1949, that I last saw the deceased alive on* Nov 28 *, 1949, and that death occurred at* 5 *a. m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Gill Hall MD M. D. | 1631 E. North Ave | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 3, 1949 | Holy Rosary | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | Rita Friedfeld | 900 E. Biddle St |

VS 150

6

93D

G80400

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 970.8

G80400
Registered No.

1. NAME OF DECEASED (Type or Print): MARY HUGHES — N-979.0
2. DATE OF DEATH: November 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1410 N. Decker Avenue — 8-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Sept 16, 1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | New York | |

13. FATHER'S NAME: Baruch Conniff
14. MOTHER'S MAIDEN NAME: Theresa McElroy

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| ✓ | ✓ | |

17. INFORMANT: Mr. Hughes — ADDRESS: 1418 N. Decker Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Digitalis poisoning | |
| DUE TO | | |
| ANTECEDENT CAUSES (B) | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 1410 N. Decker Avenue |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| November 29, 1949 ?a m. | | Ingestion of 60-80 digitalis pills |

22. *I certify that I took charge of the remains described above, held on* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Dec. 1/49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Winston for Williams, M.D. | Rita Wiedefeld | |

VS 151

1639

G80401

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 307

Registered No. G80401

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD A. PSZCZOLKOWSKI
Edward A. Pszczolkowski.

2. DATE OF DEATH Nov 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 6-14
D. STREET ADDRESS (If rural, give location) 2001 E. Fayette Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Aug. 16 1918 | 31 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bar tender | Restaurant | Baltimore Md. | U. S. A. |

13. FATHER'S NAME: John Pszczolkowski

14. MOTHER'S MAIDEN NAME: Josephine Goralski

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | War 2 | | Mrs. Berthe Pszczolkowski | 2001 E. Fayette |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Delirium Tremens

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic Alcoholism

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Possible Chronic Bromide Intoxication

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME, (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-26-, 1949 *to* 11-30-, 1949 *that I last saw the deceased alive on* 11-29-, 1949, *and that death occurred at* 2.05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. H. Kaan M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Dec 3/49 | Holy Rosary Cem | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Timothy J. Williams | John M. Welby | 401 S. Chester St |

VS 150

77D

G80402

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420-0 Registered No. G80402

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) Lauretta or(Loretta) C. Ward | 2. DATE OF DEATH Nov. 30, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3710 Hayward Ave., | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18 |
| c. Length of stay in Baltimore Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 3710 Hayward Ave., |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Oct. 4, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Gamse Lithographing Co. | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? Barkman | ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 212-01-4166 | Martin J. Ward | 3710 Hayward Ave., |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: ??

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — DUE TO — ??

(C) — ??

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1949 *to* Nov 30, 49, *that I last saw the deceased alive on* Nov 1949 *and that death occurred at* 1.50 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel H Culos M. D. | 5611 Pimlico Rd | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-3-49 | Lorraine Park | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Courtney for Williams, MD | G. Howard Strong | 3207 W. North Ave., |

VS 150

8

937

G80403

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

Registered No. G80403

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAHLON LONNIE GORE

2. DATE OF DEATH: Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 104 S. Carrollton Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 104 S. Carrollton Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | married | July 22, 1874 | 75 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | Fish preserve packing | Golden Hill, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Noah Gore | Sarah |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Elmer W. Gore | 104 S. Carrollton Av |

MEDICAL CERTIFICATION

| 18. CAUSE OF DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive Cardio-Vascular Disease | 10yrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Generalized Arteriosclerosis with Parkinsonism | 10yrs. |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D | | Nov. 30, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/2/49 | Glen Haven Cem. | A. A. Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

939

G80404

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

491

Registered No. G80404

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. Edwin C. Snowman

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

c. Length of stay in Baltimore: Yrs. 2 da Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Highlands
D STREET ADDRESS (If rural, give location): 4027 Annapolis Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 4/12/1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Soda Root Beer | Baltimore Md | U S A |

13. FATHER'S NAME: Frederick Snowman

14. MOTHER'S MAIDEN NAME: Josephine Krueger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16 SOCIAL SECURITY NO

INFORMANT: Mrs Carrie E. Snowman ADDRESS: 4027 Annapolis Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anuria + Anoxemia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diffuse Bronchial Pneumonia — 1 week

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary oedema — 3 days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 30 1949 *to* Dec. 1, 1949 *that I last saw the deceased alive on* Dec. 1, 1949, *and that death occurred at* 1 30 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. Schaffer M. D. | Bon Secours Hosp. | 12/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Holy Redeemer | 4430 Belair Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 1949 | for Williams, M.D. | John J. Cowan & Son | 2 Hollins St. |

VS 150

107

G80405

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80405

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Johnson

2. DATE OF DEATH: November 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Kentucky
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lexington.
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | 12-10-1878 | 70 71 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Horse Groomer | Race Horses | Lexington, Ky | U.S.A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Lucy Johnson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | — | Mrs Grace Johnson | 1439 Argyle Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-26, 1949 *to* 11-26, 1949, *that I last saw the deceased alive on* 11-26, 1949, *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip D. Nagley M. D. | JOHNS HOPKINS HOSPITAL | 11-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/2/49 | Mt. Auburn | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Minnie Johnson Williams, M.D. | Charles R. Law | 802 Madison Ave. |

VS 150

937

G80406

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 754.0

G80406

BIRTH NO. H-90980

1. NAME OF DECEASED (Type or Print): Augustine Charles A Harris

2. DATE OF DEATH: Nov 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hosp.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-03
D. STREET ADDRESS (If rural, give location): 1414 Fraction St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Infant | 10/9/47 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Baltimore, Md. | |

13. FATHER'S NAME: James M. Harris

14. MOTHER'S MAIDEN NAME: Florence E. Harris

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| — | — | Florence E. Harris - 1414 Fraction |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tetralogy of Fallot — INTERVAL BETWEEN ONSET AND DEATH: Entire life

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-21 19 49 *to* 11-29 19 49 *that I last saw the deceased alive on* 11-29, 19 49 *and that death occurred at* 3 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lucius W. Sears M.D. | President Hosp. | Dec. 1 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/2/49 | Arbutus Mem. Park | Arbutus, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | Chas. R. Law | 802 Madison Ave. |

VS 150

157E

C80407 C80407

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Mackey
2. DATE OF DEATH: 11-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 683-Vine St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 683-Vine St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | Col. | Single | Nov. ? 1861 | 88 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Easton Stone Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Mackey
14. MOTHER'S MAIDEN NAME: Rebecca Bonney
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Bertha White ADDRESS: 683 Vine St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying; e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA OF COLON
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 1947 *to* 11/27 1949, *that I last saw the deceased alive on* 11/18 1949, *and that death occurred at* 6:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Cruton Grant M. D.
23B. ADDRESS: 601 N. Carrollton
23C. DATE SIGNED: 12/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Dec 2
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: A. Halstead - 918 - 46E
ADDRESS: Dund Hill Ave.

VS 150

G80408 BALTIMORE CITY HEALTH DEPARTMENT 49° G80408

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Henry Brooks
2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 135-Enon alley
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: City
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 135-Enon alley

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | Col. | married | May 9 1898 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Spartanburg S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Brooks
14. MOTHER'S MAIDEN NAME: Alma ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Gladys Brooks ADDRESS: 135-Enon alley

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 Days 6 Days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-27 1949 *to* 11-29 1949, *that I last saw the deceased alive on* 11-29 1949 *and that death occurred at* 1:35 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Garland Spindle M. D.
23B. ADDRESS: 902 W. Franklin
23C. DATE SIGNED: 11-30-49

24A. BURIAL? CREMATION? REMOVAL (Specify): Burial
24B. DATE: 12-2-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, Town, or County) (State): Catonsville Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: W. Halstead ADDRESS: 918-108 Druid Hill Ave.

VS 150

BIRTH NO. G80409

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80409

1. NAME OF DECEASED (Type or Print): JAMES OSBORNE BRUNER

2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1202 Myrtle Ave. 17-03

5. SEX: M
6. COLOR OR RACE: Cherokee Indian
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: December 28, 1893
9. AGE (In years last birthday): 55 56
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James H. Bruner
14. MOTHER'S MAIDEN NAME: Clara Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary V. Bruner ADDRESS 1202 Myrtle Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary sclerosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Nov. 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/2/1949
24C. NAME OF CEMETERY OR CREMATORY: Balto. National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR ADDRESS: Holland Funeral Home 1631 Druid Hill Ave.

VS 151

94a

G80410 G80410

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 770

1. NAME OF DECEASED (Type or Print): MARY ELIZA WEST
2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1554 N. Carey Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1554 N. Carey Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widow | Dec. 1, 1878 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Cape Charles, Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Custis Stokley | Eliza West |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Ella Butler 1554 N. Carey St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ca of Rectum — INTERVAL BETWEEN ONSET AND DEATH: 1 yr 1 mo
DUE TO
(B) Removal of Left Breast
DUE TO
(C) From History (B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct 28, 1948, *to* Nov 29, 1949, *that I last saw the deceased alive on* Nov - 28, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Donald Bando M. D. | 2445 Druid Hill Ave. | Dec. 1, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 4, 1949 | Arbutus Memorial Pk. | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 1 - 1949 | Nanette Lee Williams, Mgr | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

50

G80411

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 196

G80411 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE WILLIAM YEAGER

2. DATE OF DEATH 11/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SINAI HOSP.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-06
D. STREET ADDRESS (If rural, give location) 3457 KESWICK ROAD

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Oct. 22-1892 | 57 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Repairman
10B. KIND OF BUSINESS OR INDUSTRY Md. & Pa. Railroad
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Yeager
14. MOTHER'S MAIDEN NAME Virginia Zepp
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 705-10-8999
17. INFORMANT Mrs. Mary A. Yeager ADDRESS 3457 Keswick Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ASPIRATion Pneumonia
DUE TO
(B) Bulbar paralysis
DUE TO
(C) Metastatic Ca of spine

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/18, 1949 *to* 11/30, 1949 *that I last saw the deceased alive on* 11/30, 1949, *and that death occurred at* 3 p m., *from the causes and on the date stated above.*

23A. SIGNATURE William Yeager M. D.
23B. ADDRESS Sinai Hospital
23C. DATE SIGNED 11/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Dec. 3-1949
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park
24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland

DATE RECEIVED BY LOCAL REGISTRAR DEC 1 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

VS 150

5512

BIRTH NO. Checked by Medical Examiner

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9 80.0 Registered No. G80412

1. NAME OF DECEASED (Type or Print): MARGARET WINDSOR — 2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parkville
D. STREET ADDRESS (If rural, give location): 3031 Putty Hill Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | (Widowed) | Feb. 8-1888 | 61 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Fred. Kraisser
14. MOTHER'S MAIDEN NAME: Lizzie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Charles Hinden ADDRESS: 3031 Putty Hill

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebellar hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO
(B) Hypertensive arteriosclerosis — unknown
DUE TO
(C) Cardio-vascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED BY
For Dr. William Aanmer
A. A. Mercell
ASST. MEDICAL EXAMINER

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus — 10-12 years
Fracture left femur — 8 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3031 Putty Hill Rd.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 27, 1949 ? P.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell down cellar steps to floor

22. I hereby certify that I attended the deceased from Nov 23 1949 to Nov 30, 1949, that I last saw the deceased alive on NOV 30, 1949, and that death occurred at 7 A. m., from the causes and on the date stated above.

23A. SIGNATURE: Joseph Shea M. D.
23B. ADDRESS: W. B. & H.
23C. DATE SIGNED: 11-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/3/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Pk
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE: Minnie [illegible]
25. FUNERAL DIRECTOR: Leonard Luck ADDRESS: 5305 Harford

VS 150

186a

G80413

BALTIMORE CITY HEALTH DEPARTMENT 60

# CERTIFICATE OF DEATH

Registered No. G80413

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT L. ZIMMERMAN

2. DATE OF DEATH 11/30/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 15-28

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2802 ROSLYN AVE #16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | WHITE | | 6/29/1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| OFFICE WORKER | | Pa. | |

13. FATHER'S NAME FREDERICK ZIMMERMAN

14. MOTHER'S MAIDEN NAME Isabell McHenry

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | MILDRED A. ZIMMERMAN | 2802 Roslyn Ave #16 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. it means the disease, injury or complication which caused death.)

(A) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Gangrene lg, left. — 3 W 0 9.

DUE TO

(C) Diabetes Mellitus — life

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Severe Cardiac Murmur

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/24, 1949 *to* 11/30, 1949, *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* 11:50 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. L. Mantz Lab. M.D. | Maryland General Hosp. | 11/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Meadowridge Cem. | Howard Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | [illegible] | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

61

G80414

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

450.0 G80414

Registered No.

1. NAME OF DECEASED (Type or Print): Laura May Pollitt

2. DATE OF DEATH: 11-30-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest 600 South Sanatorium Chapel gate

C. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and the township): Baltimore 27-15
D. STREET ADDRESS (If rural, give location): 2211 West Rogers Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 5-17-1878
9. AGE (In years last birthday): 71 — If Under 1 Year: Months 6, Days 13 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Adolph Letzer
14. MOTHER'S MAIDEN NAME: Sophia Weaver
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: --
17. INFORMANT: Mr Weaver 4311 Wiltshire Ave Baltimore 6, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Manic depressive psychoses — 20 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-23-49 *to* 11-30-49, *that I last saw the deceased alive on* 11-29-49 *and that death occurred at* 12:15 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Melvin N. Borden, M.D.
23B. ADDRESS: 2030 W. Fayette St
23C. DATE SIGNED: 11-30-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/2/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

97

G80115

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 yr. 1

G80115

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Harry Jackson

2. DATE OF DEATH 11/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-10 L

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

D. STREET ADDRESS (If rural, give location) 3247 E. Baltimore St.

c. Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 9/3/1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unknown | Unknown | Pa. | |

13. FATHER'S NAME Mark Jeremiah Jackson

14. MOTHER'S MAIDEN NAME Hanks

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| unknown | unknown | | Hospital records | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio sclerotic cardio vascular disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerosis severe generalized — DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/28/49, 19__, *to* 11/29/49, 19__, *that I last saw the deceased alive on* 11/29/49, 19__, *and that death occurred at* 11 44 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William B. Cooper Jr. M. D. | 1213 Light St. | 11/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 3, 1949 | Parkwood Cem. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Registrar for Baltimore, Md. | John A. Moran | 3000 E. Balto St. Balto 24. Md. |

VS 150

93D

C80416

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

57

Registered No. C80416

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anthony Ciccone (Iccone)

2. DATE OF DEATH: November 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto. General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 1127 Poplar Grove St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Labor | | Italy | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Lawrence Ciccone | Dora Marsiglia |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 218-01-2464 | Larry Ciccone | 1127 Poplar Grove St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Pancreas | ? |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pneumonia. Hypostatic congestion. Hypostatic pneumonia. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-15-49. | Mass in Root of Mesentery | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* November 7, 1949 *to* November 29, 1949, *that I last saw the deceased alive on* Nov. 29, 1949, *and that death occurred at* 11 ½ *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lemuel T. Davies M. D. | West Baltimore Gen'l Hosp | 11-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 1949 | New Cathedral Cemetery | Old Frederick Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | | Joseph Tarace Inc. | 2013 Freemont Ave |

VS 150

469

G80417

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

Registered No. G80417

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EFFIE EVERHART

2. DATE OF DEATH Nov. 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3201 E. Lombard Street

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-10
D. STREET ADDRESS (If rural, give location) 3201 E. Lombard Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | June 19, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Alfred Jones | Emma Dorsey |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S NAME AND ADDRESS |
|---|---|---|
| no | 213-03-5901 | 3201 E. Lombard Street -24 Walter S. Everhart - |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coma, Thrombosis | |
| DUE TO (B) | Angina Pectoris | |
| ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct, 1949 *to* Nov 30, 1949, *that I last saw the deceased alive on* Oct, 1949, *and that death occurred at* 12 [illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3405 E Baltimore St | 12/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/3/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 1 - 1949 | [signature] | HENRY SANDER & SONS, INC. |

VS 150

94a

C80418

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80418

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nellye J. Mehring

2. DATE OF DEATH: Nov 28 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1822 N. Broadway

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1822 N. Broadway 8-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | widow | June 7, 1876 | 73 | - | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore, Maryland | USA |

13. FATHER'S NAME: George Constance

14. MOTHER'S MAIDEN NAME: Adeline Sherwood

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | Miss Nettie Reiter - 1825 Mosher S[illegible] |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: William J. Kelpie M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 11/29/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| burial | 12/2/49 | Greenmount Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 1 - 1949 | [illegible] | HENRY SANDER & SONS, INC. |

VS 151

93D

Forms are especially important. Physicians, please write the names of towns clearly and legibly.

G80419

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80419

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BLANCHE (WASHINGTON) ROBINSON

2. DATE OF DEATH: November 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 9 North Mount Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | Single | July 5, 1915 | 34 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Washington, D.C. | U.S.A. |

13. FATHER'S NAME: John Washington.

14. MOTHER'S MAIDEN NAME: Blanche

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: William Washington. ADDRESS: 9 N. Mountbt

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Syphilitic Cardio Vascular
DUE TO Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: H. J. McClafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Nov. 29, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-3-1949 | W. Auburn Cem. | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949

REGISTRAR'S SIGNATURE: Katie Lee Williams

25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 321 N Schroeder St

VS 151

20E

G80420

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G80420

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Martha Rhone

2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 814 Preice St..

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-03
D. STREET ADDRESS (If rural, give location): 814 Pierce St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | Feb. 1, 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | St. Mary's Co., Md.. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Grace Harris | 1037 N. Fremont Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V.D disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl Kaye M.D. | ☐ / ☒ / ☐ | Nov. 29, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-2-1949 | Mt. Auburn Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 3224 Edmondson Ave |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

G80421

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 743

Registered No. G80421

1. NAME OF DECEASED (Type or Print): Frederick Hines

2. DATE OF DEATH: Nov. 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 625 Mulberry (W.) 4-02

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: October 9, 1897
9. AGE (In years last birthday): 52
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Philadelphia, Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Virginia Lewis ADDRESS: 617 W. Mulberry St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
20. AUTOPSY? YES ☒ NO ☐

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Nov. 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-2-1949
24C. NAME OF CEMETERY OR CREMATORY: W. Baltimore Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 832 N Lehmdon St

VS 151

93D

G80422

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

571.0 G80422

Registered No.

BIRTH NO. 49-22723

1. NAME OF DECEASED (Type or Print) Jimmy Jones

2. DATE OF DEATH 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY 23
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 18-02
D. STREET ADDRESS (If rural, give location) 433 N. Carey St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.

c. Length of stay in Baltimore: Yrs. 6 wks Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Single | Oct 1949 | | 1½ | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Woodland Hunter

14. MOTHER'S MAIDEN NAME Marjorie Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Mother ADDRESS Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acidosis

DUE TO

(B) Dehydration

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Infect. Diarrhea

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Malnutrition

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-15 1949 *to* 11-30 1949, *that I last saw the deceased alive on* 11-30 1949 *and that death occurred at* 1245 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Edwin M. Hubbard M.D.

23B. ADDRESS Univ. Hosp.

23C. DATE SIGNED 11-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12-3-1949

24C. NAME OF CEMETERY OR CREMATORY W.M. Auburn Cem

24D. LOCATION (City, town, or county) Balto. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1949

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 322 N Schroeder St

Vs 150

119a

G80423

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80423

1. NAME OF DECEASED (Type or Print): Wilbert Seigle

2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 228 N. Green St.

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 228 N. Green St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 228 N. Green St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | C | Widower | July 4, 1914 | 35 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | | A. A. County Md. | U. S. A. |

13. FATHER'S NAME: Edward Seigle.

14. MOTHER'S MAIDEN NAME: Dorothy Brisco

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Arnold Jamison — ADDRESS: 713 N. Bruce St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 12, 1949 *to* Nov. 30, 1949, *that I last saw the deceased alive on* Nov. 30, 1949, *and that death occurred at* 9 p. m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph W. Kellam M. D. | 716 N. Johns | 12/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | State |
|---|---|---|---|---|
| Burial | 12-2-1949 | Mt. Auburn Cem. | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 1949 | | Mrs Katie R. Williams | 3221 W. Lafayette Ave |

VS 150

13B

G80424

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80424

BIRTH NO. 49-13772

1. NAME OF DECEASED (Type or Print): Clifton Wright, (Andrew)

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 23 19-02
D. STREET ADDRESS (If rural, give location): 1032 N. Gilmanst.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Sing. | June 24 1949 | | 5 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | | Md | USA |

13. FATHER'S NAME: Clifton Wright

14. MOTHER'S MAIDEN NAME: Clarence Thelma

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mother | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acidosis
DUE TO
(B) Dehydration
DUE TO
(C) Pneumonia Lobar

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-28, 1949 *to* 11-29, 1949, *that I last saw the deceased alive on* 11-28 1949, *and that death occurred at* 8:00 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edwin M. Hallerand M. D. | Univ. Hosp. | 11-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-2-1949 | Mt Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Huntington Williams | Mrs Katie R. Williams | 322 N |

VS 150

1192

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80425

BALTIMORE CITY HEALTH DEPARTMENT 443

# CERTIFICATE OF DEATH

Registered No. G80425

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Anderson-ANUSZEWSKI

2. DATE OF DEATH: Nov-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: 47 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-01
D. STREET ADDRESS (If rural, give location): 403 S. Washington St. #31

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 7/18/1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore | |

13. FATHER'S NAME: William Fabiszaka

14. MOTHER'S MAIDEN NAME: Catherine Zubrowski

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Deceased | Above |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Intracerebral Hemorrhage | |
| DUE TO | hypertensive cardio-vascular disease | 1 yr. |
| (B) | | |
| DUE TO | | |
| (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/6 1949 *to* 11/28 1949, *that I last saw the deceased alive on* 11/28 1949, *and that death occurred at* 5:55 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Pomeroy M. D. | Mercy Hospital | 11/29/49 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Holy Rosary | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 1949 | Washington Williams, M.D. | M. F. SADOWSKI & SONS | 1808 Eastern Ave |

VS 150

93D

G80426

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80426

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John H. Trainor

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 122 Arbutus Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 3, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Food Broker | | Baltimore, Md | U.S.A. |

13. FATHER'S NAME: James L.W. Trainor

14. MOTHER'S MAIDEN NAME: Monika Mink

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | | Patient | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Myocardial infarction | 1 Hr |
| DUE TO (B) | Coronary occlusion | 1 Hr |
| DUE TO (C) | Arteriosclerotic Heart Disease | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-18-49 | Internal & External Hemorrhoids & Thrombosis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-28-49, 19__, *to* 11-30-49, 19__, *that I last saw the deceased alive on* 11-30, 1949, *and that death occurred at* 6 55 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ray J. Brady Jr. M.D. | Union Memorial Hosp | 11-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 2, 1949 | Baltimore | E. North Ave Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Registrar for Baltimore, Md. | Trustee E. Donovan | 3818 Roland Ave |

VS 150

937

G80427

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

60

Registered No. G80427

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barbara E. Hoskins

2. DATE OF DEATH: Nov. 30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3428 Edmondson Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-08
D. STREET ADDRESS (If rural, give location): 3428 Edmondson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | Widow | Jan. 24, 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.W. | Own home | Balto. Md. | |

13. FATHER'S NAME: Peter Easter

14. MOTHER'S MAIDEN NAME: Joanne Turner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs. Joanna Hoskins, 3428 Edmondson A |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic Coma — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Diabetes Mellitus — 1946

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerosis — 1946

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 46 *to* Nov 30, 1949 *that I last saw the deceased alive on* Nov 29, 1949 *and that death occurred at* 1:15 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo A Strauss M. D. | 1800 N Charles St | Dec 1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 3/49 | Loudon Pk. 3801 Frederick Rd. | Balto. 29, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | Hunting for Williams, M.D. | Harry A. Wintzfeldt | 4101 Edmondson Ave. |

VS 150

61

G80428 ✓ 53 G80428

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Mother Mary Gertrude Peters

2. DATE OF DEATH: Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5712 Roland Ave.
c. Length of stay in Baltimore: 22 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5712 Roland Ave 27-3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | March 9, 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rochester, N. Y.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Peters
14. MOTHER'S MAIDEN NAME: Magdalene Ludwig

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Monastery Records ADDRESS: 5712 Roland Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Recto Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: Nov. 1948
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION: Aug 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma Rectum + Liver
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 19[illegible] *to* Nov 30, 19[illegible], *that I last saw the deceased alive on* Nov 30, 19[illegible], *and that death occurred at* 6.55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] Krause M. D.
23B. ADDRESS: 116 E. Chase St
23C. DATE SIGNED: 12/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/2/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 - 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: H. M. Means Son
ADDRESS: 808 N Calvert St 467

VS 150

G80429

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80429

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rev. Francis A. Kiniry

2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland The Seton Institute

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Seton Institute 6420 Reisterstown Rd.

C. Length of stay in Baltimore: Yrs. 6 Mos. 15 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: N.Y.
B. COUNTY: N.Y.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bronx
D. STREET ADDRESS (If rural, give location): 2860 Webb Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 1877 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Catholic Priest
10B. KIND OF BUSINESS OR INDUSTRY: Religious
11. BIRTHPLACE (State or foreign country): Yonkers, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Kiniry
14. MOTHER'S MAIDEN NAME: Bridget O'Meaghen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: None
17. INFORMANT: Seton Institute ADDRESS: 6420 Reisterstown Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia | 4 days |
| DUE TO (B) | General arteriosclerosis. Dia- betes mellitus | 1½ years |
| DUE TO (C) | Psychosis with cerebral arterio- sclerosis | 1½ years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/18 19 49 *to* 12/1 19 49, *that I last saw the deceased alive on* Dec. 1 19 49, *and that death occurred at* 2 03 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Walter O. Salerno M.D.
23B. ADDRESS: The Seton Institute Balto
23C. DATE SIGNED: Dec. 1 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 3/49
24C. NAME OF CEMETERY OR CREMATORY: New York City
24D. LOCATION (City, town, or county) (State): New York

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108 W. North Ave

VS 150

61 City #1.

G80430

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 410

Registered No. G80430

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Collenberg

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 25-05
D. STREET ADDRESS (If rural, give location): 1073 Church St. - Brooklyn

5. SEX: MALE
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 6-6-1885
9. AGE (In years last birthday): 64
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Worker
10B. KIND OF BUSINESS OR INDUSTRY: Wurtzburger
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Collenberg
14. MOTHER'S MAIDEN NAME: Catherine Herman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Margaret C. Collenberg ADDRESS: 1073 Church St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RLEUMATIC CARDIO VASCULAR
DUE TO
(B) DISEASE & MITRAL STENOSIS AND GRADE III FAILURE
DUE TO
(C) BILATERAL PLEURAL EFFUSION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/30, 1949 *to* 11/30, 1949 *that I last saw the deceased alive on* 11/30, 1949, *and that death occurred at* 4:25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: St. Agnes Hosp.
23C. DATE SIGNED: 11/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/3/49
24C. NAME OF CEMETERY OR CREMATORY: Balto.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Cook Sons ADDRESS: 1217 St. Paul St.

VS 150

92B

G80431

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80431
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Chas H. Link
2. DATE OF DEATH: Dec 1st 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3020 Lock Raven Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 9-04
D. STREET ADDRESS (If rural, give location): 3020 Lock Raven Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 6/24/1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Butcher | Germany | |

13. FATHER'S NAME: (Unknown) Link
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Martha Link | 3020 Lock Raven Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from; natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| William G. Helfrich M.D. | | 12/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | Woodlawn | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

94a

To Foster
G80432
2803 Harrison Blvd

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No. G80432

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SADIE S. SMITH.

2. DATE OF DEATH: Dec 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2803 Harrison Blvd
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harrison Nursing Home.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3000 Kenwick Road 13-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | married | April 7, 1883 | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Maryland | U.S. |

13. FATHER'S NAME: Daniel Koller.
14. MOTHER'S MAIDEN NAME: Margaret ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Harvey E. Smith | 3000 Kenwick Rd |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Influenza (Uremia) | 4 days |
| DUE TO (B) | Hypo-Cardiac Chronic Nephritis | 3 years |
| DUE TO (C) | | |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* April 1949 *to* Dec 1, 1949, *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 4:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert O. Foster M. D. | 2824 St. Paul St | Dec 2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5 1949 | Manchester | Carroll Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Irvington Williams, M.D. | Trenton E. Donovan | 3818 Roland Ave |

VS 150

131B

G80433

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80433

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Neistadt

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-12
D. STREET ADDRESS (If rural, give location): 3920 Reisterstown Rd.

5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: 1874
9. AGE (In years last birthday): 75 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Harry Cohen
14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Goldie Eisenberg ADDRESS 3619 Rosedale Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARCINOMA SIGMOID
DUE TO
(B) CACHEXIA
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/27, 1949 *to* 12/1, 1949, *that I last saw the deceased alive on* 12/1, 1949, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: [illegible]
23C. DATE SIGNED: 12/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 2, 1949
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rosedale Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, Md
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS 1126 W North Ave

VS 150

46E

G80434

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

570.3

Registered No. G80434

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Lorenz

2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hosp

C. Length of stay in Baltimore: 78 Yrs. Mths. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-07
D. STREET ADDRESS (If rural, give location): 2808 Bovernwood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Jan 2 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md | USA |

13. FATHER'S NAME: Augustus Lorenz

14. MOTHER'S MAIDEN NAME: Catherine Betz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | 212-16-8042 | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — (Interval between onset and death): 3 days

DUE TO

(B) Gangrene of Bowel — (Interval between onset and death): ?

DUE TO

(C) Volvulus of Sigmoid — (Interval between onset and death): 4 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-21-49 | Volvulus of Sigmoid | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11 20 1949 *to* 12 - 1 1949, *that I last saw the deceased alive on* 12-1 1949, *and that death occurred at* 8 25 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Carl E. Gordon M. D. M. D. | Union Memorial Hospital | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 3-1949 | Parkwood | Taylor ave Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 2 - 1949 | [illegible] | Howard S Markline Woodlawn Md |

VS 150

122 B

G80435

BALTIMORE CITY HEALTH DEPARTMENT E 8 12.4 N-C 04.2

# CERTIFICATE OF DEATH

Registered No. G80435

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joshua Edward Arrington Jr.

2. DATE OF DEATH: Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 226 E. 27th St. 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | July-17-1942 | 7-4-13 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School Boy | School | Baltimore, Md. | |

13. FATHER'S NAME: Joshua G. Arrington

14. MOTHER'S MAIDEN NAME: Dorothy M. Bohleter

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Mrs. Jacqueline A. Carroll | Balto. Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture, skull
DUE TO Sub-dural hemorrhage
(B) Contusion, brain
DUE TO Fracture, left femur
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Street | 27th St. and Gilford Ave. 12/3 |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 30, 1949 3:25 P.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Pedestrian struck by automobile |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | ☐ ☐ ☐ | Dec. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 3/49 | Loudon Park Cems. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | [illegible] for Williams, M.D. | Stewart & Mowen Co. | 108 W. North Ave. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1710 City #1.

G80436.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

99-8 G80436
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Miss Rosa Frendenthal

2. DATE OF DEATH: Nov. 30, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland Balt Wd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): maryland Gen. Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. Md. Roguestage
D. STREET ADDRESS (If rural, give location): 704 Dunkirk Rd. #12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | 4/24/1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): German.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Frendenthal
14. MOTHER'S MAIDEN NAME: Bertha Levi
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mr. W. E. Duck. ADDRESS: 704 Dunkirk Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: generalized Calcinomatosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO: of genital urinary

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 year

19A. DATE OF OPERATION: 9/26/49
19B. MAJOR FINDINGS OF OPERATION: generalized Calcinomatosis
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/21/49, 19__, *to* 11/30, 1949, *that I last saw the deceased alive on* 11/30, 1949, *and that death occurred at* 10:40 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. E. Martin M. D.
23B. ADDRESS: maryland Gen. Hosp.
23C. DATE SIGNED: 11/30/49

24A. BURIAL, *CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Dec/2/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: Timothy for Williams, M.D.
25. FUNERAL DIRECTOR: Stewart & Mowen Co. ADDRESS: 108 W. North Ave.

VS 150

55E City #1.

*Correct age is especially important. Typewriter, pencil or ball point pen must be used. Sign in ink.

G80437 ✓ Corr. 1 G80437

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): CHESTER ARTHUR HELLEN ?

2. DATE OF DEATH: NOV. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4654 YORK RD.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO.
D. STREET ADDRESS (If rural, give location): 4654 YORK RD. 27-11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | SINGLE | DEC. 8, 1884 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CLERK | DRUGS | MD. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JOHN F. HELLEN | LILLY BINYON |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 218-03-7007 | MISS B.T. HELLEN | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chron Myocarditis | 5 yrs |
| DUE TO | Acute arteriolar Nephritis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Acute Cardiac Decompensation | 3 mths |
| DUE TO | | |
| (C) | Chron Substituted Nephritis | 5 yrs |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 4, 1949 *to* Nov 30, 1949, *that I last saw the deceased alive on* Nov 30, 1949, *and that death occurred at* 6 6 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. W Bishop M. D. | 503 Thunder Ln | Dec 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC. 3, 1949 | GREENMOUNT | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Registrar for Williams, M.D. | H.W. JENKINS & SONS CO. | 4905 YORK RD. |

VS 150

1310

C80438

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

53.4

Registered No. C80438

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Arménton Davis

2. DATE OF DEATH Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 755 W. Lexington St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 755 W. Lexington St. 4-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Married | July 6, 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Raleigh N.C. | U.S.A. |

13. FATHER'S NAME: Mark Pope

14. MOTHER'S MAIDEN NAME: Lucy ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Wm. Davis, 755 W. Lexington St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Septicemia | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George H. Merrill M.D. | | Dec. 1, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Shipped | 12-3-49 | Raleigh N.C. | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | [illegible] | A. HALSTEAD | 918 Druid Hill Ave. |

VS 151

24a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80439
MS--132989

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59

G80439
Registered No.

1. NAME OF DECEASED (Type or Print): Warthal Blunt

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 607 N. Fremont Ave. Zone 17

17-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | June 2, 1909 | 40 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Deceased

14. MOTHER'S MAIDEN NAME: Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Baltimore City Hospitals Records--4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Chronic glomerulonephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-28- 1949 *to* 11-30- 1949, *that I last saw the deceased alive on* 11-30- 1949, *and that death occurred at* 7:25 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. L. Rogers M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 12-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 2, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion
24D. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 1949
REGISTRAR'S SIGNATURE: Registrar for Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1601 Druid Hill Ave.

131 B

Dr Gordy

G80440

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 Registered No. G80440

1. NAME OF DECEASED (Type or Print): Peter James Franz

2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3006 Gilton Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-44
D. STREET ADDRESS (If rural, give location): 3006 Gilton Ave

5. SEX: male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: July 15-1863
9. AGE (In years last birthday): 86 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Andrew Franz
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Raymond Franz ADDRESS: 3006 Gilton

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B) Chronic myocarditis — 5 years
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: June 1949
19B. MAJOR FINDINGS OF OPERATION: Cancer of Prostate
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): no
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): none
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* April 15 1948 to Dec 1 1949, *that I last saw the deceased alive on* Nov 29 1949, *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. L. Gordy M.D.
23B. ADDRESS: 570 Harford Rd
23C. DATE SIGNED: 12-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-3-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county): Balto (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Leonard J. Leck ADDRESS: 5205 Harford

VS 150

6

51B

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G80441

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80441
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Louis Wm. Wagner

2. DATE OF DEATH 30 1 Dec 1949

3. PLACE OF DEATH
a. Baltimore City, Maryland 4703 Hampnett Ave

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
4703 Hampnett Ave
Pine Ridge Nursing Home

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-44
d. STREET ADDRESS (If rural, give location) 3209 Hilltop Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Nov. 25 1867 | 82 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Tailor | | Baltimore Md | |

13. FATHER'S NAME Wm. Edward Wagner

14. MOTHER'S MAIDEN NAME ✓

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| (If yes, give war or dates of service) | | Mrs Louis Wagner | 3107 Glenmore |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | (24 Nov 1949) 7 Days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis - Generalized | — |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | — | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 11 Nov. , 1949 to 1 Dec. , 1949, *that I last saw the deceased alive on* 30 Nov , 1949, *and that death occurred at* 1:55 p.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Osborne M.D. | 5202 Harford Rd | 1 Dec 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | Parkwood | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Penitentiary Williams, M.D. | Leonard J. Luck | 5305 Harford |

VS 150

83R

G80442

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

150

Registered No. G80442

1. NAME OF DECEASED (Type or Print): John Francis Hahan

2. DATE OF DEATH: 11/30/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1466 William St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY 1466 William St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore - Md.
D. STREET ADDRESS (If rural, give location) 1466 William St 24-C

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M. | W | Married | 12 27 1885 | 63 | 11 | 29 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tailor

10B. KIND OF BUSINESS OR INDUSTRY: Dept Store

11. BIRTHPLACE (State or foreign country): Baltimore.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Hahan

14. MOTHER'S MAIDEN NAME: Marg. Caverly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 213-10-6112

17. INFORMANT: Mrs L J Hahan. ADDRESS: Same.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

(B) Carcinoma of Esophagus — 8 mo (?)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter Kohn, M. D.

23B. ADDRESS: 1026 Fort Ave

23C. DATE SIGNED: 12/1/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/3/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Cross

24D. LOCATION (City, town, or county) (State): Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: J. J. Fahey & Sons

ADDRESS

VS 150

46a

G80443

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80443

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Blanch Magee

2. DATE OF DEATH: 11/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1128 E Lombard

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 1128 E Lombard St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 1128 E Lombard St. 3-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | B. | Divorced | 7/10/1910 | 39 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Canning House | Tomato Packer | Md | USA |

13. FATHER'S NAME: George E. Johnson

14. MOTHER'S MAIDEN NAME: Mary Harris

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Geo Johnson | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-25, 1949 *to* 12-1, 1949, *that I last saw the deceased alive on* 29 Nov, 1949, *and that death occurred at* 10 4 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. C. Burwell M.D. | 121 Aisquith St. | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/2/49 | Sacred Heart. | Edmondson Ave Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Huntington Williams, M.D. | J. J. Fahey & Sons | |

VS 150

1313

G80444 Medical Examiner Case ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420.0

Registered No. G80444

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KOPPELMAN, ABRAHAM

2. DATE OF DEATH: DEC. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland DOA

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore: 45 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 7-02
D. STREET ADDRESS (If rural, give location): 2210 ASHLAND AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | June 25, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Grocer Business | Own Business | RUSSIA | — |

13. FATHER'S NAME: Chaim Koppelman

14. MOTHER'S MAIDEN NAME: Unkown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | SARAH KOPPELMAN - LANDLADY | 2210 ASH-LAND AV. BA |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: ? 3 hours.

DUE TO

ANTECEDENT CAUSES

(B) Coronary thrombosis

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Arteriosclerotic Heart Disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
For: Dr. Wm. G. Helfrich
B. E. Fischer M.D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (Give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 1, 1949 *to* Dec 1, 1949 *that I last saw the deceased alive on* Dec 1, 1949 *and that death occurred at* 2.10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Abram Koppelman M. D. | Sinai Hospital | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Dec 4, 1949 | Hebrew Washington Rd Cem | Baltimore | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 1949 | Huntington Williams | Sol Levinson & Bros | 1126 W North Ave |

VS 150

93D

G80445 Vol. 1 G80445

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith Bradley

2. DATE OF DEATH: 11/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 60 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 943 N. Castle St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 943 N. Castle St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | Jan 27 1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Daniel Reynolds
14. MOTHER'S MAIDEN NAME: Helen McOmber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Harry Hook ADDRESS: Hampstead Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Perinephric Abcess | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hydronephrosis Bilateral | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/28, 1949 *to* 11/28, 1949, *that I last saw the deceased alive on* 11/28, 1949, *and that death occurred at* 2 A m. 11/29 *from the causes and on the date stated above.*

23A. SIGNATURE: Mag Miller M.D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 11/29

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 2/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cem
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Phelps Henry Sons ADDRESS: 2024 Eutaw St

VS 150

133B

BIRTH NO. G80146

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80146

1. NAME OF DECEASED (Type or Print): Mrs. Martha Blanche Pyles

2. DATE OF DEATH: December 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home 3520 Hilton Road

c. Length of stay in Baltimore: 60 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2404 Maryland Avenue 12-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Jan. 28, 1869
9. AGE (In years last birthday): 80 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin B. Spicer
14. MOTHER'S MAIDEN NAME: Mary Frances Sahtmyer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT: Mrs. Hattie M. Eckert ADDRESS: 1402 Yeager Street

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio Vascular Disease. — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic nephritis — DUE TO — 3

(C) Arteriosclerosis — 2

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct 26, 1949, *to* Dec 1, 1949, *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 10:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Johnson P. Welch Jr. M. D.
23B. ADDRESS: 1227 Wash Blvd
23C. DATE SIGNED: 12-2-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 5, 1949
24C. NAME OF CEMETERY OR CREMATORY: St. Mary's Hampden
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: Curtis Tom Williams, M.D.
25. FUNERAL DIRECTOR: Burgee Funeral Home ADDRESS: 3631 Falls Road

VS 150

1310

G80447 ✓ G80447

BIRTH NO 49-11027

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 05 3.4

Registered No.

1. NAME OF DECEASED (Type or Print): COLUMBUS SANDERS

2. DATE OF DEATH: November 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: 6 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 618 Roundview Road 25-32

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Single | 5/30/1949 | | 5 / 6 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Infant | - | Baltimore Md. | U.S.A. |

13. FATHER'S NAME: Columbus Sanders

14. MOTHER'S MAIDEN NAME: Alpurnia Baysmore

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Alpurnia Baysmore (M) | 618 Roundvie |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia--causative organism — INTERVAL BETWEEN ONSET AND DEATH

DUE TO unidentified

(B) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(C) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George S. Merrill M.D. | | 11-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/2/49 | Mt. Calvary Cem. | A.A.County, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Curtis [illegible] Williams, M.D. | Charles H. Corpus | 5th Eastern Ave |

VS 151

24a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80448

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80448

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LAURENCE PAUL CARNAHAN

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ill.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chicago
D. STREET ADDRESS (If rural, give location): 7130 Norman Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 11/28/00 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Utilityman | Seafarer | Ill. | USA |

13. FATHER'S NAME: Peter Carnahan

14. MOTHER'S MAIDEN NAME: Kathleen O'Donovan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| YES | WWI | 341-01-1327 | Records- | US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of right lung with secondary bronchiectasis and suppurative pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Nov. 15, 1949, *to* Dec. 1, 1949 *that I last saw the deceased alive on* Dec. 1, 1949, *and that death occurred at* 10:35P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/2/49 | Bloomington Ill. | Bloomington Ill. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 1949 | Registrar for Williams, Inc. | Earl B. Moulton | 403-E-25th St. 47 |

VS 150

G80449

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80449 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Baker Williams

2. DATE OF DEATH: Dec 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 729 aisquith st

c. Length of stay in Baltimore: 15 years. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 729 aisquith st 10-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widowed | Sept 23 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | S. C. | |

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Clinton S. Agnew | 1024 Edmondson ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/3 19[illegible]9, to 12/1 19[illegible]9, *that I last saw the deceased alive on* 11/28 19[illegible]9 *and that death occurred at* [illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Pinto Grant M. D. | 601 N. Carrollton | 12/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-4-49 | Arbutus | arbutus md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Hunter for Williams, M.D. | George S. Nelson | 1303 Presstman st |

Vs 150

46E

G80450

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

60

G80450 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Barbara Hawkins

2. DATE OF DEATH: Nov 29, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1523 Winchester st
c. Length of stay in Baltimore: 40 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1523 Winchester st 16-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | married | March 28 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | at Home | Wash D. C. | |

13. FATHER'S NAME: Joseph Makel

14. MOTHER'S MAIDEN NAME: Katherine ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | George W. Hawkins | 1523 Winchester st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the left antrum of face

DUE TO

(B)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

Generalized Arteriosclerosis & Hypertension

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial Insufficiency, Inanition

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 1948 *to* Nov 29, 1949 *that I last saw the deceased alive on* Nov. 29, 1949 *and that death occurred at* 8:15 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gilbert L. Caspied M. D. | 722 N. Fulton Ave | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-4-49 | Mt Auburn | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Registrator Williams, M.D. | George S. Nelson | 1303 Baltimore st |

VS 150

55D

G80451
MS—133110

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80451

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bernard Hodges

2. DATE OF DEATH 12-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 24 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 814 S Sharpe St. Zone 30

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | Mar. 22, 1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Texas | |

13. FATHER'S NAME: Ben Hodges

14. MOTHER'S MAIDEN NAME: Sarah Baker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Records--Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Syphilitic Heart Disease with Aortic Insufficiency | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-1- , 1949 *to* 12-1- , 1949, *that I last saw the deceased alive on* 12-1- 1949 *and that death occurred at* 5:30 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Rogers M. D. | B.C.H.--4940 Eastern Ave. | 12-2-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-4-49 | Mt. Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Huntington Williams, M.D. | James A. Taylor | 638 N. Gilmor St |

VS 150

30E

Correct Age if especially important. Physicians: please write the cause of death clearly with ink only.

G80452

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80452

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANCIS A. MALONE

2. DATE OF DEATH: November 29, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 900 S. Highland Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 900 S. Highland Ave. 28-11

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 30, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Steel Worker | Lebanon, Pa. | U.S.A. |

13. FATHER'S NAME: William Malone

14. MOTHER'S MAIDEN NAME: Margaret Houser

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mary M. Malone | 900 S. Highland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B) arteriosclerosis, generalized

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Mar 1, 1947 *to* Nov. 22, 1949 *that I last saw the deceased alive on* Nov 22 1949, *and that death occurred at* 7:10 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward A. Flanigan M.D. | 3503 Fait Ave. | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12- -49. | Sacred Heart Cemetery | 7401 German Hill Rd. Ba.Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | [illegible] | Charles L. Zeile | 901 S. Conkling St. |

VS 150

937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80453 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

151 Registered No. G80453

1. NAME OF DECEASED (Type or Print): MARIE SIJATZ

2. DATE OF DEATH: Dec. 2. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3113 Weaver Avenue
c. Length of stay in Baltimore: 4 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3112 Weaver Avenue 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | Jan. 11, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Germany | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frederick Forster | Christine Knoblock |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | None | Mrs. Carl Drees 3112 Weaver Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Rupture of Dissecting Aneurysm of | 6 mos |
| DUE TO | Aorta and Innominate Artery | |
| | arteriosclerosis, Generalized | 10 yrs |
| (B) | | |
| DUE TO | Hypertensive cardio-cerebral disease | 15 years |
| (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 10, 1949, *to* Dec 2, 1949, *that I last saw the deceased alive on* Dec 2, 1949, *and that death occurred at* 3:35 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Hirschfeld, M.D. | 6919 Hanford Rd | 12/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| transit- burial | 12/3/49 | Locust Wood | Camden, N.J. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 2 - 1949 | [illegible] | HENRY SANDER & SONS. INC. |

VS 150

Baltimore Maryland 96

G80454

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80454

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FRANCES A. MILLER

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clifton Nursing Home, 3502 Clifton Ave.,

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1440 Boyle St. 24-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | June 1, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Poland | |

13. FATHER'S NAME: (Unknown0 Rice

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mrs Josephine McNulty, 1901 E. Lafayette |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 9, 1949, to Dec 1, 1949, *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 6 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm H. Futterman M. D. | 2324 Reisterstown Rd | Dec. 2, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Holy Cross | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 2 - 1949 | [illegible] | William Cook, Inc., 1217 St. Paul St. |

VS 150

92D

BIRTH NO. 2 G80455

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E936.6 G80455 Registered No.

1. NAME OF DECEASED (Type or Print): FREDERICK N. GRIMES — N-863

2. DATE OF DEATH: November 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 313 N. Greene Street 4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Widowed | 3-24-1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Furniture | Used Furniture | Alexandria Va | |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | ? | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute peritonitis
DUE TO
(B) Rupture of intestine and bladder
DUE TO
(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): store
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 311 N. Greene St. (Basement) 4/2
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Unknown m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY Ooccur? While carrying furniture Probable trauma by fall or blunt force

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

23A. SIGNATURE: George L. Merrill M.D
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec. 1, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 3-49 | Loudon Park | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 - 1949
REGISTRAR'S SIGNATURE: [illegible] Williams M.D.
25. FUNERAL DIRECTOR: Ellsworth Funeral ADDRESS: 5118 Harford Ave

VS 151

186a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

ES-133675

G80456

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80456

Registered No.

1. NAME OF DECEASED (Type or Print): Sophia Michocka

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

C. Length of stay in Baltimore: 44 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2723 E. Mura Street (13) 8-03

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 15, 1880
9. AGE (In years last birthday): 69 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Herman Soba
14. MOTHER'S MAIDEN NAME: Frances
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AVE.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Urinary Tract Infection with Septicemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diabetes Mellitus and Acidosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic Heart Disease with Failure

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-23, 1949, *to* 11-30, 1949, *that I last saw the deceased alive on* 11-30, 1949, *and that death occurred at* 8:50 m. *from the causes and on the date stated above.*

23A. SIGNATURE: R. L. Ogus M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 11-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/5/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 4 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR ADDRESS: M.F. Sadowski & Sons, 1808 Eastern Avenue

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G. 3157

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80457 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): OLIVIA CATHERINE DULANEY

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5303 Purlington Way

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5303 Purlington Way

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Dec. 13, 1879 | 70 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk (rtd) | Telephone Co. | Baltimore, Md. | |

13. FATHER'S NAME: Francis I. Dulaney

14. MOTHER'S MAIDEN NAME: Charlotte E. Stier

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Miss Margaret E. Dulaney-5303 Purlington Way |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio - Renal Disease — Interval between onset and death: 11 weeks

DUE TO

(B) Arteriosclerosis.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: -

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/8, 19 49, *to* Dec 1, 19 49, *that I last saw the deceased alive on* Dec 1, 19 49 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Emmett Dulaney M. D. | Med. Sts Bldg - Balto. | 12/2/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC | | WM. J. TICKNER & SONS Balto., Md. |

VS 150

1310

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80158 ✓

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 43

G80458 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTHA VIRGINIA ROHRBACH

2. DATE OF DEATH: Dec. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3341 Elmora Ave.

C. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01
D. STREET ADDRESS (If rural, give location): 3341 Elmora Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Jan. 10, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Balto., Md. | |

13. FATHER'S NAME: John B. Martin

14. MOTHER'S MAIDEN NAME: Anna Wilson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Mr. James B. O'Toole, Jr. 4103 The Alameda |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — Interval between onset and death: 1 week

DUE TO

(B) Ch. Myocarditis

DUE TO Ch. Hypertension. Arteriosclerosis

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 20, 1949 *to* Dec 2, 1949 *that I last saw the deceased alive on* Dec 1, 1949 *and that death occurred at* 6 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J.S. Oteadwig M.D. | 3805 Belair Rd. | Dec 2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | Parkwood Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 2 - 1949 | Hunter Van Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80459 BALTIMORE CITY HEALTH DEPARTMENT G80459

# CERTIFICATE OF DEATH

BIRTH NO. 170 Registered No.

1. NAME OF DECEASED (Type or Print): AGNES J. LOVELL
2. DATE OF DEATH: 12/2/49
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster Md
D. STREET ADDRESS (If rural, give location): 46 Liberty St.
5. SEX: female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Apr 14, 1899
9. AGE (In years last birthday): 50 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Thomas Jones
14. MOTHER'S MAIDEN NAME: Frances Reese
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: self ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Infarct — DUE TO

ANTECEDENT CAUSES

(B) Carcinoma of breast — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

19A. DATE OF OPERATION: 4/6/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of breast.
20. AUTOPSY? YES ☐ NO ☒
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/3/ 1947 to 12/2/ 1949 that I last saw the deceased alive on 12/2/ 1949, and that death occurred at 9:45 A.m., from the causes and on the date stated above.

23A. SIGNATURE: Charles Le Blanc Jr. M.D.
23B. ADDRESS: Maryland General
23C. DATE SIGNED: 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 5-49
24C. NAME OF CEMETERY OR CREMATORY: Baust
24D. LOCATION (City, town, or county) (State): Carroll Co

DATE RECEIVED BY LOCAL REGISTRAR: DEC 2 1949
REGISTRAR'S SIGNATURE: Deputy for Nathan Wilmer
25. FUNERAL DIRECTOR: H Barnard Son ADDRESS: Westminster Md

correct age is especially important. Physician: please write the cause of death clearly and legibly.

50

G80460

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80460

1. NAME OF DECEASED (Type or Print): L. L. BRADSHAW

2. DATE OF DEATH: December 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): docked on Light St. City of Richmond Bay Line Boat
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Messinick
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | 1897 | 52 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel Bradshaw
14. MOTHER'S MAIDEN NAME: Rosa Watkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Maddie Bradshaw ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary Thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec. 2, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | Western Cemetery | Messinick, Va. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: McNabb and Lockhart ADDRESS: 94a Virginia

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80461

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E978.0 G80461

Registered No.

1. NAME OF DECEASED (Type or Print): WALTER HARRIS — N-806

2. DATE OF DEATH: 11:12 a.m. Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 14-03
D. STREET ADDRESS (If rural, give location): 1403 Fremont Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | M | 1905 | XX 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Auto Mechanic | | Wash. D. C. | U. S. A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Mary A.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Olivia Harris 1403 N. Fremont Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dislocation of cervical vertebra

DUE TO with contusion of cervical cord

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1403 Fremont Avenue

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 2 p.m. 11-29-49

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Jumped from roof of 2nd story

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [X], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 11-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/4/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn

24D. LOCATION (City, town, or county) (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 3 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Geo.G. Kelson 1308 Presstman St.

VS 151

164 E

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80462

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80462

1. NAME OF DECEASED (Type or Print) FLORENCE SHELBURNE

2. DATE OF DEATH December 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09
D. STREET ADDRESS (If rural, give location) 1110 E. Federal Street

5. SEX female
6. COLOR OR RACE white
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED~~ (Specify) Widowed
8. DATE OF BIRTH 1/17/1889
9. AGE (In years last birthday) 60
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Toby Purdue
14. MOTHER'S MAIDEN NAME Catherine Bradberry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT James Shelburne ADDRESS 1110 E. Federal St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED Dec. 1, 1949

24A. ~~BURIAL, CREMATION~~, REMOVAL (Specify) Removal
24B. DATE 12/3/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~ Fairview
24D. LOCATION (City, town, or county) (State) Roanoke Va.

DATE RECEIVED BY LOCAL REGISTRAR DEC 3 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm Cook Inc. ADDRESS 1217 St. Paul St.

VS 151

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80463

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E974.0 G80463 Registered No.

1. NAME OF DECEASED (Type or Print) EDWARD STEWART — N-991

2. DATE OF DEATH December 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 9-09
D. STREET ADDRESS (If rural, give location) 1316 Aisquith Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Widowed | 12/1/1884 | 65 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gate Maintenance
10B. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME (Unknown) STEWART
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-05-6337
17. INFORMANT John Edward Stewart ADDRESS 1316 Aisquith St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Strangulation due to
DUE TO hanging
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1316 Aisquith Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) December 1, 1949 12.10 p.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self from cellar rafter by rope

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Dec. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/5/49
24C. NAME OF CEMETERY OR CREMATORY Balto
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 3 - 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc 127 St. Paul St.

VS 151

164a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80464

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. G80464

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM A. BRUNING

2. DATE OF DEATH December 1, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-15
D. STREET ADDRESS (If rural, give location) 6101 Alto Avenue

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | M. | May 13, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanist | Shipyard | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| unknown | unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 218-10-3988 | Florence Bruning | 6101 Alto Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertrophy and dilatation of heart — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Coronary artery disease.

DUE TO

(C) Polycystic kidneys.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | ☐ / ☒ / ☐ | Dec. 2, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county & State) |
|---|---|---|---|
| Burial | 12/5/49 | Western | Edmondson Av. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3 - 1949 | Permit for Williams, Jr. | Mildred I. Bleight | 6009 Harford Rd |

VS 151

95c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80465

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G80465

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) (CATHIE) Catherine Price

2. DATE OF DEATH Dec. 1, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1431 S. Hanover St.

b. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto 22-01

D. STREET ADDRESS (If rural, give location) 1431 S. Hanover St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | widowed | Jan 28. 1856 | 93 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Balto

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown Wm ZESCH

14. MOTHER'S MAIDEN NAME Barbara Grubert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Martha Straten ADDRESS 1431 S. Hanover St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-Vascular Disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED Dec. 2, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/5/49

24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet

24D. LOCATION (City, town, or county) (State) Frederick Co Md

DATE RECEIVED BY REGISTRAR DEC 3 1949

REGISTRAR'S SIGNATURE Huntington for Williams, M.D.

25. FUNERAL DIRECTOR Mildred I. Blight ADDRESS 6009 Harford Rd

937

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80466 Melvin Wade

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 12-7 G80466
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Melvin WADE HARRIS N-86 r. 2

2. DATE OF DEATH: Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-10
D. STREET ADDRESS (If rural, give location): 605 N. Clinton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S. | Mar 21-1941 | 8 | 8 / 9 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Scholboy
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Melvin Harris
14. MOTHER'S MAIDEN NAME: Linda Platt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Melvin Harris ADDRESS 605 N. Clinton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushed chest

DUE TO

(B) Rupture of spleen

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

I

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Linwood & Mackelberry St. 7/1
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 30, 1949 3:15 P.M.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Pedestrian struck by bus

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X] suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec. 1, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Zion Lutheran | Hermes Run Balto. Co. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Philip Henrig Sons ADDRESS 2024 Orleans St

VS 151

170c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AE-133873
80467

BALTIMORE CITY HEALTH DEPARTMENT 053.4 G80467
# CERTIFICATE OF DEATH
Registered No.

BIRTH NO. 49-05436

1. NAME OF DECEASED (Type or Print) Kenneth Kilmon

2. DATE OF DEATH 12-1-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3-02
D. STREET ADDRESS (If rural, give location) 1109 E. Baltimore St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Single | March 5- 1949 | | 8 | 27 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Kilmon

14. MOTHER'S MAIDEN NAME Lillian Kapple

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Baltimore City Hospitals Records: 4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Septicemia ? | |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

CERTIFICATION APPROVED BY
For: Dr. Wm. G. Helfrich
P.B. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1- , 1949 *to* 12-1- , 1949, *that I last saw the deceased alive on* 12-1- , 1949, *and that death occurred at* 2.02P m., *from the causes and on the date stated above.*

23A. SIGNATURE G. L. Rozen M. D.

23B. ADDRESS Baltimore City Hospitals

23C. DATE SIGNED 12-2-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Schwartz | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR DEC 3 - 1949

REGISTRAR'S SIGNATURE [illegible] for Williams, M.

25. FUNERAL DIRECTOR Lillie Zeiler Inc ADDRESS Balto. Md.

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER 24a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80468

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80468

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carlener Church.

2. DATE OF DEATH: Nov. 29, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland — Baltimore City

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 505 N. Arlington Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — B. COUNTY: 505 N. Arlington Ave.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 18-02
D. STREET ADDRESS (If rural, give location): 505 N. Arlington Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | C | Widow | Feb. 15, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Eastern Shore, Va. | |

13. FATHER'S NAME: Dan Rogers.

14. MOTHER'S MAIDEN NAME: Susie Bailey.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| No | | Blanche Bailey. 505 N. Arlington |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

DUE TO

(B) Hypertension — 2-3 yr

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-15-1949 to 11-29, 1949 *that I last saw the deceased alive on* 11-29-, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. LeRoy Berry M.D. | 1420 E Chase | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-3-1949 | Arbutus Memorial | Arbutus Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3 - 1949 | Huntington Williams, M.D. | Mrs Ketura Ribellimus | 3521 Edmondson |

VS 150

83a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80469

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80469 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Owens

2. DATE OF DEATH 11-30-1949

3. PLACE OF DEATH: Baltimore City, Maryland 1334 Druid Hill Ave

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

b. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 17-02
D. STREET ADDRESS (If rural, give location) 1334 David Hill Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | married | Feb 24, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Greenville S.C. | |

13. FATHER'S NAME John Owens

14. MOTHER'S MAIDEN NAME Ella ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mamie Owens | 1334 Druid Hill Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Dilatation
DUE TO
(B) Myocarditis
DUE TO
(C) Chronic Gastritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Hernea Scrotal

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 8, 1949 *to* 11-30 1949 *that I last saw the deceased alive on* 11-30 1949 *and that death occurred at* 9P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm R. Booker M.D. | 1133 N. Monroe | 12-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5, 1949 | Mt. Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3 - 1949 | Huntington Williams, M.D. | Mrs Kate R. Williams | 3224 Schroeder St |

VS 150

93E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80470

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80470

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry B. H. Young

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1921 Etting St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 14-03
D. STREET ADDRESS (If rural, give location): 1921 Etting St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Married | Oct. 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Young | Mollie Butler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Sadie Young | 1921 Etting St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Nephritis & Cardiac Disease — Interval between onset and death: 1yr 6 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 1948 *to* Dec 1, 1949 *that I last saw the deceased alive on* Dec 1, 1949 *and that death occurred at* 9A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jno. A. Julian Jr. M. D. | 5117 Schroeder & Baltimore Md | 12/2/49. |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-5-1949 | Arbutus Memorial | Arbutus, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3 - 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 322 N Schroeder St |

VS 150

1316

G80471

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80471

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel I Abrams

2. DATE OF DEATH: Dec 2, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3501 Reisterstown Road

b. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 3501 Reisterstown Road

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: July 4, 1879
9. AGE (In years last birthday): 70
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman
10B. KIND OF BUSINESS OR INDUSTRY: New York Pants Co
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Abrams
14. MOTHER'S MAIDEN NAME: Miriam Samuels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Sol Greenberg ADDRESS: 3501 Reisterstown Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 16 days

DUE TO

(B) Coronary Insufficiency — 2 wks

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1936 *to* 10/12 1947, *that I last saw the deceased alive on* 10/12 1947, *and that death occurred at* 8A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Dr M S Greenberg M. D.
23B. ADDRESS: 2426 Eutaw Place
23C. DATE SIGNED: 12-1-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 4, 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Hebrew Cem
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 3 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

94a

correct age is especially important. Physician: please write the cause of death clearly and legibly

G80472

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17°

Registered No. G80472

1. NAME OF DECEASED (Type or Print): Celia Princus

2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 65 Yrs. [redacted] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-11
D. STREET ADDRESS (If rural, give location): 3406 Dolfield Ave #15

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Caac | W | 1-25-84 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Balto | U.S.A |

13. FATHER'S NAME: Baruck Balk

14. MOTHER'S MAIDEN NAME: Bessie Balk

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Grace Fine | 5805 Gwyn Oak Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary edema | 2 Days. |
| DUE TO (B) | carcinomatosis | 5 yrs |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Adenocarcinoma breast | 5+ yrs. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-23, 1949 *to* 12-1, 1949, *that I last saw the deceased alive on* 11-30, 1949, *and that death occurred at* 8:20 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ruth Bleier M. D. | Sinai Hosp. | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 4, 1949 | Southern Ave Cemetery | Southern Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3- 1949 | Lucretia Johnson Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

50

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80473 ✓ 331 G80473

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | LUCY ELLZEY GOLDSMITH |
| 2. DATE OF DEATH | Dec. 1, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 3017 Windsor Ave. |
| c. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 3017 Windsor Ave. 15-47 |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | July 27, 1868 |
| 9. AGE (In years last birthday) If under 1 year: Months / Days / If under 24 hours: Hours / Min. | 81 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | home |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md, |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | John W. Brown |
| 14. MOTHER'S MAIDEN NAME | Mary V. Gray |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO | no |
| 17. INFORMANT | Mr. Sidney W. Goldsmith |
| ADDRESS | 3017 Windsor Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral hemorrhage | 10 min. |
| DUE TO (B) | Senility | 1½ yr. |
| DUE TO (C) | Arteriosclerosis | ? |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 5/17 1941, *to* 12/1 1949 *that I last saw the deceased alive on* 11/29 1949, *and that death occurred at* 9 57 m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE M. D. | Roberta. Reuter | |
| 23B. ADDRESS | 3408 Windsor Ave | |
| 23C. DATE SIGNED | 12/2/49 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 12/3/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Cathedral Cem. | |
| 24D. LOCATION (City, Town, or county) (State) | Baltimore, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | DEC 3 1949 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, M.D. | |
| 25. FUNERAL DIRECTOR | WM. J. TICKNER & SONS | |
| ADDRESS | Balto., Md. | |

VS 150

83a

680474

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

680474

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Margery F. Beckman

2. DATE OF DEATH: 12/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 27-14
D. STREET ADDRESS (If rural, give location): 501 Wingate Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | widowed | June 8, 1885 | 64 | 6 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home duties | | Pa. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John R. Findlay | Ella C. Fridley |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Margery E. Beckham | 500 Wingate Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic P.V disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| C. L. Tubinski M.D. | | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5/49 | Evergreen Cemy | Gettysburg Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3 - 1949 | Huntington Williams, M.D. | John D. Mitchell & Sons | 920 Eutaw Pl |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80475 DUHAN ✓ G80475

BALTIMORE CITY HEALTH DEPARTMENT No. 1

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): John Duhan

2. DATE OF DEATH: Dec 2-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

c. Length of stay in Baltimore: 70 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto 26-03

D. STREET ADDRESS (If rural, give location): 3213 Ramona Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Nov 10-1873 | 76 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | Shoe Store | Austria Hungary | |

13. FATHER'S NAME: George Duhan

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —

16. SOCIAL SECURITY NO.: 243-09-5535

17. INFORMANT: Mrs Edward Duhan ADDRESS: 3213 Ramona Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ? Acute Pulmonary Oedema

DUE TO

(B) ? Coronary Occlusion

DUE TO

(C) Generalised arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

? Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 - 1, 1949 *to* 12 - 2-, 1949 *that I last saw the deceased alive on* 12 - 2, 1949 *and that death occurred at* 12·45 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. H. Kaan M. D. | St. Joseph Hospital | 12-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5-49 | Holy Redeemer Cem | Balto |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 3 1949 | REGISTRAR'S SIGNATURE: [illegible] for Williams Jr

25. FUNERAL DIRECTOR: Jos J Herr & Son ADDRESS: 3001 Eutaw Ave 94a

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80476

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80476

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie Lawrence

2. DATE OF DEATH Nov. 26 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 408 Laurens st

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-03
D. STREET ADDRESS (If rural, give location) 408 Laurens St

5. SEX Female
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 1884
9. AGE (In years last birthday) 65
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. R. Lee — ADDRESS 1500 Kenilworth ave Washington D.C.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arterio Sclerotic C.V. Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE Earle Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED 27 NOV 49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE Dec. 3 1949
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn
24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 1 - 1949
REGISTRAR'S SIGNATURE Huntington Williams M.D.
25. FUNERAL DIRECTOR Charles A. Rice — ADDRESS 661 W. Baltimore St

939

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80477 ✓ X 43 G80477

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Hannemann, Hannah E.

2. DATE OF DEATH: Dec. 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harundale
D. STREET ADDRESS (If rural, give location): 604 Binsted Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | May 15, 1882 | 67 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Nurse | Nurse (Practical) | Baltimore, Md. | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mrs. Grace M. Storm, 604 Binsted Rd., / ADDRESS: Harundale, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebrovascular hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease — DUE TO

(C) Diabetes Mellitus
Carcinoma of rectum

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/8/ , 1949, *to* 12/1 , 1949, *that I last saw the deceased alive on* 12/1 , 1949, *and that death occurred at* 9:45A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Andrew Aleck M. D. | St. Joseph's Hosp. | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/3/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3 - 1949 | Thurlington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

469

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80478

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1 1 G80478 Registered No.

1. NAME OF DECEASED (Type or Print): MR. LEWIS C. SCHEFFENACKER

2. DATE OF DEATH: 12-2-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: LIFETIME (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12-03
D. STREET ADDRESS (If rural, give location): 2807 GUILFORD AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | WIDOWED | 1-14-1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| TRAVELING SALESMAN | | BALTIMORE, MARYLAND | |

13. FATHER'S NAME: MR CHARLES SCHEFFENACKER

14. MOTHER'S MAIDEN NAME: ELIZABETH PRELLER Pruller

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| UNKNOWN | | |

17. INFORMANT: PATIENT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B)
(C) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Carcinoma of prostate

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/20/, 1949, *to* 12/4/, 1949, *that I last saw the deceased alive on* 12/2/, 1949, *and that death occurred at* 10P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H. Watts, M.D. | Union Memorial Hospital | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12-5-49 | New Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 3- 1949 | Huntington Williams, M.D. | WM. J. TITTER & SONS INC. | North & Pa. Aves Balto. 17, Md. |

VS 150

51B

Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G80479

G80479

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 331 Registered No.

1. NAME OF DECEASED (Type or Print) Florence B Coddington

2. DATE OF DEATH Dec 3/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4700 Harford Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Snyder Nursing Home

C. Length of stay in Baltimore 90 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 1432 N. Fulton Ave 15-02

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH April 1/1863

9. AGE (In years last birthday) 86 If under 1 Year: Months, Days. If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Phila Pa

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James B Smith

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT J Frank Smith ADDRESS 1261 Kenny St N.E. Washington DC

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension

DUE TO

(C) Senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1949 *to* Dec 3, 1949, *that I last saw the deceased alive on* Dec 2 1949, *and that death occurred at* 11 A., m., *from the causes and on the date stated above.*

23A. SIGNATURE Legal Seal Leslie M. D.

23B. ADDRESS 300 E. North Ave

23C. DATE SIGNED 12-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec 6/1949

24C. NAME OF CEMETERY OR CREMATORY Glenwood

24D. LOCATION (City, town or county) (State) Washington DC

DATE RECEIVED BY LOCAL REGISTRAR DEC 4 - 1949

REGISTRAR'S SIGNATURE Timothy Williams, M.D.

25. FUNERAL DIRECTOR Harry A. Ignacio ADDRESS 4204 Hedgewood Ave

VS 150

839

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80480 BALTIMORE CITY HEALTH DEPARTMENT G80480

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) HANNAH DOUGLAS

2. DATE OF DEATH December 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 749 Wilmer Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | Married | Oct. 11 1916 | 33 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housetec | | Washington D.C | U.S.A. |

13. FATHER'S NAME David Williams
14. MOTHER'S MAIDEN NAME Ida Battle

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT |
|---|---|---|
| | | Edna Battle-N.W. Wash. 20 25 Dt. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Tuberculosis | |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| H. J. McCafferty M.D. | | 12-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/6/49 | Rocky Mount, N. C. | Rocky Mount, N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 - 1949 | Washington Williams, M.D. | W. Halstead - 918- 130 Rhode Island Ave | |

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80481

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80481 Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Brooks, Mrs. Maomi | 2. DATE OF DEATH: 12-3-49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md. B. COUNTY: Anne Arundel |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hosp. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glen Burnie |
| c. Length of stay in Baltimore: 3 (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location): Box 33 Oakwood Rd |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | July 7, 1890 | 68 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Housewife | Pennsylvania | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edward Knoup | Emma Bashore |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Robt. Leard | 34 Gentian Lane |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach — (INTERVAL BETWEEN ONSET AND DEATH) 3 mos.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 3, 1949 *to* Dec. 3, 1949 *that I last saw the deceased alive on* Dec 3, 1949 *and that death occurred at* 11:A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Heaton M. D. | Church Home + Hosp. | Dec. 3, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Mont Rose | York Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 1949 | Hattie [illegible] for Williams, M.D. | Paul E. Schnaare | 3615-17 Belair Rd |

46 B

G80482 ✓ X G80482

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 581.0

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Sidney JOHN A DURHAM

2. DATE OF DEATH 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home + Infirmary

c. Length of stay in Baltimore Aberdeen ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD.
B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
D. STREET ADDRESS (If rural, give location) RFD #2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M | Feb. 19, 1900 | 49 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physical Science Aid

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOHN DURHAM

14. MOTHER'S MAIDEN NAME Willie Hershberger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. —

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cirrhosis of Liver | 1 yr, |
| DUE TO | (B) Oesophageal Verices | 1 wks. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/1 , 19 49 *to* 12/3 , 19 49 , *that I last saw the deceased alive on* 12/3 , 19 49 , *and that death occurred at* 5 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert E. Sisk M. D. | Church Home Hosp. | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-5-49 | OLD BRICK BAPTIST Cemetery | Carrollville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 - 1949 | Thurlington Williams M.D. | Henry Jarrett Sons | Aberdeen Md. |

VS 150

1240

Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G80483 CERTIFICATE CORRECTED 12-30-49 ✓ G-0183

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (Mrs.) Mary George

2. DATE OF DEATH: 12-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland general Hosp

c. Length of stay in Baltimore — Yrs. / Mos. / Days: 27-48

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5600 Lothian Road #12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married ~~Widowed~~ | Sept. 12th 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | North Carolina | |

13. FATHER'S NAME: Charles Jones

14. MOTHER'S MAIDEN NAME: Mittie Marshburn

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Mrs. Shannahan | Balto. Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Hypetensive cardiovascular disease — 8 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-1, 1949, *to* 12-3, 1949 *that I last saw the deceased alive on* 12-3, 1949 *and that death occurred at* 7:45 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louisa Candler M.D. | Maryland general Hosp. | 12-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | Jones Burial Ground | Jones Co. N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 1949 | Huntington Williams, M.D. | Lansdale Funeral Home | 7401 Belair Rd. |

VS 150

93D

Please write clearly and legibly. Physician: please write the cause of death clearly and correct ago is especially important.

G80184 ✓ G80184

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): BARNETT SHPRITZ

2. DATE OF DEATH: DEC. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3616 Springdale Ave.
c. Length of stay in Baltimore: 49 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-38
D. STREET ADDRESS (If rural, give location): 3616 Springdale Avenue

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. Last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | July 16, 1884 | 65 | 4 | 17 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant - Haberdashery Bus.
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Shpritz
14. MOTHER'S MAIDEN NAME: Esther Horowitz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Howard Shpritz - ADDRESS: 4103 Maine Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute Cardiac Dilatation — 15 minutes

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1949 *to* 12-3, 1949 *that I last saw the deceased alive on* 12-2 1949 *and that death occurred at* 12.45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. G. Broomer M.D.
23B. ADDRESS: 1109 N. Calvert St
23C. DATE SIGNED: 12-3-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-4-49
24C. NAME OF CEMETERY OR CREMATORY: Beth Tfiloh Org.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 4 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson & Bros. ADDRESS: 1124-26 Lord Avenue

VS 150

937

C80485

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80485
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John H. Schuman

2. DATE OF DEATH: Dec. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR [redacted]: St. Joseph's

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 24-02
D. STREET ADDRESS (If rural, give location): 412 E. Gitting St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W. | Married | 7/1/883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Paper hanger | | Baltimore | |

13. FATHER'S NAME: John H. Schuman

14. MOTHER'S MAIDEN NAME: Catherine Baker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs. J. H. Schuman | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiogenic Carcinoma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949, *to* Dec. 2, 1949 *that I last saw the deceased alive on* Dec. 2, 1949, *and that death occurred at* 5:25 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Joseph Kreis M. D. | 1400 N. Caroline St | Dec. 2, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/6/49 | Holy Cross | Ritchie Highway |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 - 1949 | Lucretia for Williams, M.D. | J. J. Fahey & Sons | |

VS 150

47c

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G80486

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 80486

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael Grangan

2. DATE OF DEATH: Dec. 3, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Ohio
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dayton
D. STREET ADDRESS (If rural, give location) 3321 E. 5th St

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | — | 2-4-49 | | 9 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Ohio | |

13. FATHER'S NAME: Eugene Grangen

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post Operative Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B)

DUE TO

(C) Congenital Heart

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 16, 1949 *to* Dec. 3, 1949, *that I last saw the deceased alive on* Dec. 3, 1949 *and that death occurred at* 1:50 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James L. Gamble M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| | Dec 12/49 | Woodside Cem | Ohio | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 1949 | Evelyn Williams, M.D. | Chas P. Towell | 2427 Edmondson Ave |

157E

PLEASE WRITE PLAINLY. WILL UNDERTAKER PLEASE ENTER NAME OF CEMETERY? Physicians: please write the cause of death clearly and legibly. correct age is especially important.

G80487 ✓ G80487

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 434 ✓

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Jan.(or) John Kowalczyk

2. DATE OF DEATH: Dec,1.1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1626 Thames Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home

c. Length of stay in Baltimore: 35 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 31- 2-03
D. STREET ADDRESS (If rural, give location): 1626 Thames Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Marred | March 31 1883 ? | 66 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Poland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Kowalczyk | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 222-05-5244 | Katherine Kowalczyk 1626 Thames Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac asthma — INTERVAL BETWEEN ONSET AND DEATH: 8 mo

DUE TO

(B) Hypostatic Pneumonia — 2 days

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1 Nov 1949 *to* 1 Dec 1949, *that I last saw the deceased alive on* 1 Dec 1949, *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 503 E Fayette Ave | 2 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec.5,1949 | St.Stanislaus Cemetery | Baltimore,Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 4 - 1949 | Director for Williams, M.D. | George A.Weber 705 South Ann Street |

VS 150

95c

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80488 G80488

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

163 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Casimir Zanto

2. DATE OF DEATH: Dec. 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 119 S. Regester Street
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 31 2-02
D. STREET ADDRESS (If rural, give location): 119 South Regester Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March ? 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Watchman | Baltimore City Dept. | Baltimore, Md. | |

13. FATHER'S NAME: John Zanto

14. MOTHER'S MAIDEN NAME: Mary Zapolowicz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Katherine Zanto | 119 S. Regester Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Acute Cordiac Dilatation | 12-2-49 |
| DUE TO (B) | Pneumonia of Lung. | 5-1-49 |
| DUE TO (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 1, 19 49, *to* Dec 2, 19 49, *that I last saw the deceased alive on* May 1, 19 49 *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Bauer M. D. | 801 Kenwood Ave | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 6-1949 | St. Stanislaus Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 - 1949 | Huntington for Williams, M.D. | George A. Weber | 705 South Ann Street |

VS 150

479

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Especially important. Physician: please write the cause of death clearly and legibly.

G80489 BALTIMORE CITY HEALTH DEPARTMENT G80489

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Mary Or Maryanna Rozga

2. DATE OF DEATH Dec.2,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1712 Lancaster Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home

C. Length of stay in Baltimore 68 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore-31, 2-03
D. STREET ADDRESS (If rural, give location) 1712 Lancaster Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | October 26,1862 | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

13. FATHER'S NAME Thomas Novak

14. MOTHER'S MAIDEN NAME Katherine SZCZPANIAK

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Helen Fabiszak 1712 Lancaster Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis | 12-1-49 |
| DUE TO (B) | Chr. Myocarditis | 12-1-48 |
| DUE TO (C) | Generalized Arterio-Sclerosis | 1940 |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 5, 1940, *to* Dec 2, 1949, *that I last saw the deceased alive on* Dec 2, 1949, *and that death occurred at* 10:45 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Ryan M.D. | 806 N Kenwood Ave | 12/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec.6,1949 | St.Stanislaus Cemetery | Baltimore,Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 4 - 1949 | Investigator Williams, M.D. | George A.Weber 705 South Ann Street |

VS 150

937

Please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Physician:

G80490 BALTIMORE CITY HEALTH DEPARTMENT G80490

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Marie A. Boisvert
2. DATE OF DEATH: Dec. 3, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: 40 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-1
D. STREET ADDRESS (If rural, give location): 204 E Preston
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 6 1863
9. AGE (In years last birthday): 83 — If Under 1 Year: Months / Days — If Under 1 Hour: Hours / Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Adam Roy
14. MOTHER'S MAIDEN NAME: Louise Tetreault
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Daughter Mrs M. J. B. Costello — ADDRESS 2040 Preston St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(B) Cardiac Failure
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 20, 1949, to Dec 3, 1949 *that I last saw the deceased alive on* Dec 3, 1949, *and that death occurred at* 12:04 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Mary E. Mathieu M. D.
23B. ADDRESS: Mercy Hospital.
23C. DATE SIGNED: 12/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/6/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 4 - 1949
REGISTRAR'S SIGNATURE: Funeral for Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Williams & Son — ADDRESS: 805 N. Calvert St.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as far as possible. Information under items 18 and 19 is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

107

G80491 G80491

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Otto Molz

2. DATE OF DEATH 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Maryland
D. STREET ADDRESS (If rural, give location) 4309 Fernhill Ave 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct 19/1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lithographer | | Maryland | |

13. FATHER'S NAME Francis Molz

14. MOTHER'S MAIDEN NAME Unknow

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Julia - (wife) | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/3/49 *to* 12/3/49 *that I last saw the deceased alive on* 12/3, 19__, *and that death occurred at* 2:55 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Blanchard M.D. | Maryland General | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 6/1949 | New Cathedral | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 - 1949 | Huntington Williams, M.D. | Harry A. Cunard | 4204 Ridgewood Ave |

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80492

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80492

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Louise Conrad

2. DATE OF DEATH: Dec 2 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2032 N.Washington St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 80 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 2032 N.Washington St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | Sept 19 1859 | 90 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Housewife | Frederick Md | |

13. FATHER'S NAME: August Schroeder

14. MOTHER'S MAIDEN NAME: Gertrude Santmeyer

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Edna C.Conrad | 2032 N.Washington St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chron Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B) Acute Cardiac dilatation — 2 wks

DUE TO

(C) muscle loss muscle weak heart muscle

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 1948 *to* Dec 2, 1949, *that I last saw the deceased alive on* Dec 2, 1949 *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. H. Bishop M. D. | 303 Studeba | Dec 2 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5 1949 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 4 - 1949 | Livingston Williams, M.D. | Henry H. Limacoe | 4204 Ridgewood Ave |

VS 150

93D

Please write plainly. Physician: please write the cause of death clearly and legibly. Special attention is especially important. Please write the cause of death clearly and legibly.

G80493 G80493

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Atlee Inglis

2. DATE OF DEATH: Dec 3/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 4201 Ridgewood Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 4201 Ridgewood Ave

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 25/1884
9. AGE (In years last birthday): 65 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

8a. Length of stay in Baltimore: 50 Yrs. Mos. Days

10. USUAL OCCUPATION (Give kind of work, even if retired): Construction Contractor
10a. KIND OF BUSINESS OR INDUSTRY: Whiting Turner Co
11. BIRTHPLACE (State or foreign country): Lancaster Pa.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles A. Inglis
14. MOTHER'S MAIDEN NAME: — Lowery.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-07-6890
17. INFORMANT: Elizabeth M Inglis ADDRESS 4201 Ridgewood Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ? Hours Dead on arrival still warm

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1945, 19__, *to* 1949, 19__, *that I last saw the deceased alive on* 10/31/49, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. C. Harper M. D.
23b. ADDRESS: 5701 Berwyn Oak Ave
23c. DATE SIGNED: 12/3/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 6/1949
24c. NAME OF CEMETERY OR CREMATORY: Druid Ridge
24d. LOCATION (City, town, or county) (State): Pikesville Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 4 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.
25. FUNERAL DIRECTOR: Henry H. Inman
ADDRESS: 4204 Ridgewood Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correct age is especially important. Physician: please write the cause of death clearly and legibly.

94a

G80494

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17

G80494

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ERNESTINE HOFMANN

2. DATE OF DEATH: December 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Belllona & Belvedere
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Edgewood Nursing Home
c. Length of stay in Baltimore: 80 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 N. Linwood Avenue

7-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widowed | June 16, 1867 | 82 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Akron, Ohio | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Smith | unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Matilda R. Hofmann - 508 N. Linwood Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cachexia | |
| DUE TO | ~~Carcinoma Uteri~~ Carcinoma Uterus | 3 mos. |
| ANTECEDENT CAUSES (B) | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | Generalized arteriosclerosis | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept, 1949 to ~~Dec.~~ Nov. 4 1949 *that I last saw the deceased alive on* Dec. 2, 1949 *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| K. Kunkerty, M.D. M. D. | 244 N Milton Ave | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 5, 1949 | Parkwood Cemetery | 3310 Taylor Ave., Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 4 - 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 150

48C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80495

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80495 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Abraham Plotkin

2. DATE OF DEATH: 12-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
C. Length of stay in Baltimore: 33 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-04
D. STREET ADDRESS (If rural, give location): 12 No Washington St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year, months, days. If under 24 hours, hours, min.) |
|---|---|---|---|---|
| Male | W | married | | 77 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | | Russia | |

13. FATHER'S NAME: Laba

14. MOTHER'S MAIDEN NAME: not known

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Ida Plotkin | 12 No Washington St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-2, 1949, *to* 12-3, 1949, *that I last saw the deceased alive on* 12-3, 1949, *and that death occurred at* 6:32 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerome Gabel M. D. | Sinai Hosp | 12-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-4-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 - 1949 | for Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80496

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80496

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Butler

2. DATE OF DEATH: 12/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: Yrs. 3 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: AA.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mayo
D. STREET ADDRESS (If rural, give location)

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH
9. AGE (In years last birthday): 56 yrs
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): South River Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Emma Gaylor ADDRESS: Mayo

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis

DUE TO

(B) origin probably bile duct

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 9/12/49
19B. MAJOR FINDINGS OF OPERATION: Generalized carcinomatosis
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/26/49, 1949, to 12/4/49, 1949, that I last saw the deceased alive on 12/4/49, 19__, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE: William B. Cooper Jr. M. D.
23B. ADDRESS: South Balto Gen. Hosp
23C. DATE SIGNED: 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Dec-6-1949
24C. NAME OF CEMETERY OR CREMATORY: Hopes Chapel Cem
24D. LOCATION (City, town, or county) (State): South River Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: J. A. Hardesty & Son ADDRESS: Glenburnie Md.

VS 150

46F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80197

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 163

Registered No. G80197

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1025 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) since Nov 8, 1949

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County Dorchester
(c) City or town Cambridge Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Pine St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** James Walter Jewell

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-10-6912

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col | ~~Single~~ Married |

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aged 53 yrs

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| Aged 53 | — | — | hr. min. |

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual Occupation Insurance Collector

11. Industry or business

FATHER
12. Name Edward Jewell
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Ellen Hackett
15. Birthplace Md.

16 (a) Informant Elizabeth Roberts Niece
(b) Address

17 (a) Burial (b) Date thereof Dec 6 1949
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wesley Cemetery
Location Cambridge, Md.

18 (a) Funeral director Herbert M. St. Clair
(b) Address Cambridge Md.

19 DEC 5 - 1949 [illegible]
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1949, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1949 to Dec 4 1949 and that I last saw h[illegible] alive on Dec 3 1949.

| Immediate cause of death | Duration |
|---|---|
| Pulmonary Edema | 1 day |
| Due to Carcinoma Lung | 4 mos |
| Due to | |
| Other Conditions None | |

(Include pregnancy within 3 months of death)

Date of operation [illegible] Not performed
Major findings of operation:
of autopsy: No

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph L. Young M. D.
Address 1424 E. Pratt St Baltimore Md. Date signed 12/4/49

VS 150

471

G80498

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80498

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Trautwein

2. DATE OF DEATH 12/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTIMORE GENERAL HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 3122 Rosalie Ave

5. SEX M
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 3/8/1864
9. AGE (In years last birthday) 85 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY Butcher
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Trautwein
14. MOTHER'S MAIDEN NAME Fredia Werner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS Russell McMiken 3122 Rosalie Ave

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/3, 1949, to 12/4, 1949, *that I last saw the deceased alive on* 12/3, 1949, *and that death occurred at* 9 50 a m., *from the causes and on the date stated above.*

23A. SIGNATURE L A Rolandelli M. D.
23B. ADDRESS WBGH
23C. DATE SIGNED 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/6/49
24C. NAME OF CEMETERY OR CREMATORY Western
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 5 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm Cook Inc. 1217 St. Paul St.

VS 150

931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80499 **CERTIFICATE CORRECTED** 12-8-49

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 1920 D. G80499

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert L. Badart

2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3911 Rokeby Rd

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 3911 Rokeby Rd. 16 08

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 7/3/1886 | 63 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10B. KIND OF BUSINESS OR INDUSTRY: Goodman Levy Co.
11. BIRTHPLACE (State or foreign country): London England
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Anton F. Badart
14. MOTHER'S MAIDEN NAME: Louise (~~illegible~~) Daborn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-09-2193
17. INFORMANT: Robt. L. Badart Jr. ADDRESS: 3911 Rokeby Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours.

DUE TO

(B) Arteriosclerotic type heart Disease with Cardiac hypertrophy and congestive failure — many years.

(C) Chronic Bronchitis - Bronchiectasis
~~Bronchial asthma~~.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 26th, 1949 *to* Dec 1, 1949, *that I last saw the deceased alive on* Nov 29, 1949 *and that death occurred at* 4.45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: W. Michel M. D.
23B. ADDRESS: 1015 Poplar Grove St.
23C. DATE SIGNED: Dec 3 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/5/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine
24D. LOCATION (City, town, or county) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: W. Cook Inc. ADDRESS: 217 St. Paul St.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80500

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G805 241 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Wm N. Ingle

2. DATE OF DEATH: 12/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 601 S. Hanover St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 601 S Hanover St 21 01

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED
8. DATE OF BIRTH: FEB. 1, 1893
9. AGE (In years last birthday): 56
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): B&O R.R.
10B. KIND OF BUSINESS OR INDUSTRY: Rail Road
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY:
13. FATHER'S NAME: CALVIN INGLE
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO:
17. INFORMANT: MISS IRMA KENNARD ADDRESS: WOODBROOK LANE -12

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Bronchial Asthma
DUE TO
(B) Chronic Alcoholism
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: P. L. Jakimenko M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 12/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/5/49
24C. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN
24D. LOCATION (City, town, or county) (State): RITCHIE HIGHWAY

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE: Printing for Williams, M.D.
25. FUNERAL DIRECTOR: JOHN F. DENNY, INC. ADDRESS: 715 LIGHT ST -30

VS 151

777

G80501

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

570.1

Registered No. G80501

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie R. Fowler

2. DATE OF DEATH: 12/3/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hosp.

c. Length of stay in Baltimore: — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md. B. COUNTY U.S.A.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-23

D. STREET ADDRESS (If rural, give location): 3195 Pennsylvania Ave.

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 3/21/1887

9. AGE (In years last birthday): 62 yrs. | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Oliver Thompson

14. MOTHER'S MAIDEN NAME: Ella

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): no

16. (If yes, give war or dates of service):

17. SOCIAL SECURITY NO.: None

18. INFORMANT: John E. Fowler

19. ADDRESS: 319 Parrish St

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MESENTERIC THROMBOSIS

DUE TO (B) TERMINAL ILEUM (2 FEET) GANGRENOUS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (C) CIRRHOSIS LIVER

(D) ABDOMINAL ASCITES

(E) MODERATE CONGESTIVE FAILURE

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/6, 1949 *to* 12/3, 1949 *that I last saw the deceased alive on* 12/3, 1949, *and that death occurred at* 12:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John E. Fowler M. D.

23B. ADDRESS: 3195 Penn Ave

23C. DATE SIGNED: 12/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR: Pott & B. M. Walters Chester

VS 150

1248

AB-133735
G80502

E400.0 G80502

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. N-E 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Annabelle N. Downey

2. DATE OF DEATH: 12-4-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-11
D. STREET ADDRESS (If rural, give location): 100 Cold Spring Lane (Nursing Home

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | Jan. 28- 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: (D

14. MOTHER'S MAIDEN NAME: (D

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia

DUE TO

(B) Fracture of neck of right femur

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
P B Fisher MD.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Nursing Home | 100 Cold Spring Lane |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fell down when she missed bottom step at stairs at home |

22. *I hereby certify that I attended the deceased from* 11-25- , 1949, *to* 12-4- , 1949 *that I last saw the deceased alive on* 12-4- , 1949, *and that death occurred at* 8 AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. S. Cozzens M. D. | Baltimore City Hospitals | 12-4-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 6-1949 | Druid Ridge | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 5 - 1949 | Washington Nolan M.D. | Bertram G. Goer 2224 Eastern Ave |

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER 186a

G80503

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

330

G80503

Registered No.

1. NAME OF DECEASED (Type or Print): Wm. Woodard.

2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.

c. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-0
d. STREET ADDRESS (If rural, give location): 1100 Whitelock St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widowed | Oct 6, 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wilson, N.C.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Jessie Woodard

14. MOTHER'S MAIDEN NAME: Lunnya Woodard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Lillian Hodges, 952 Gordon St. ADDRESS: Norfolk Va.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachno.'d hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24 1949 *to* 12-1 1949 *that I last saw the deceased alive on* 12-1 1949, *and that death occurred at* 5 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE: Louis M. Lowry M.D.

23B. ADDRESS: Provident Hosp.

23C. DATE SIGNED: 12/5/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-5-49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn

24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Charles L. Law ADDRESS: 803 Madison Ave

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80504

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 3 4

Registered No. G80504

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HELEN SMITH

2. DATE OF DEATH November 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Maryland General Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1323 Mount Royal Avenue 11-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | U | U | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral arteriosclerosis | years |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized arteriosclerosis | years |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| B. Fisher M.D. | | Nov. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | NOV 29 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] | Commissioner of Health | |

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

97

C80505

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80505

BIRTH NO. 49-25207

1. NAME OF DECEASED (Type or Print): BABY CHOATES

2. DATE OF DEATH: November 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 900 McDonogh Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 900 McDonogh Street 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | | November 18, 1949 | | | 30 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Asphyxia | |
| DUE TO | aspiration of feces | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | — | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 900 McDonogh Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-18-49 m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Aspiration of feces

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 11-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): NOV 29 1949

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1950

C80506 ✓ X

BALTIMORE CITY HEALTH DEPARTMENT 43

# CERTIFICATE OF DEATH

C80506

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CLARENCE THOMAS

2. DATE OF DEATH: 11/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univer. Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 28 Catonsville

C. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): Old Frederick Rd. Kingsdale

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | B | Separated | 1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | None | Md. | |

13. FATHER'S NAME: Clarence Thomas

14. MOTHER'S MAIDEN NAME: Mary ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Robert Scott | Conowingo |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Anoxia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiac failure

DUE TO

(C) HCVD - arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/18 1949 *to* 11/23 1949 *that I last saw the deceased alive on* 11/22 1949 *and that death occurred at* 10 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nicholas Mallis M. D. | Univ. Hosp | 11/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL NOV 29 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80507 ✓ 420.0 G80507

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HENRY SNYDER

2. DATE OF DEATH: 11-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 3-07
D. STREET ADDRESS (If rural, give location): 1022 E. LOMBARD ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | U | U | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| K | K | K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | U |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure

DUE TO

(B) Arteriosclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Marked sclerosis

INTERVAL BETWEEN ONSET AND DEATH: (illegible)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-15-, 1949 *to* 11-15-, 1949 *that I last saw the deceased alive on* 11-15-, 1949, *and that death occurred at* 9:35 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Harris M. D. | Sinai Hospital | 11-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | NOV 29 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1948 | (illegible) | Commissioner of Health | |

VS 150

8

(illegible) 93)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80508

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. C80508

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marie Harriday

2. DATE OF DEATH DEC 2 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, 27-4
D. STREET ADDRESS (If rural, give location) 4669 Falls, Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | Colored | married | Nov. 14, 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Dennis

14. MOTHER'S MAIDEN NAME Elizabeth Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Samuel Harriday ADDRESS 4669 Falls Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral vascular accident

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23A. SIGNATURE E. N. Schumacher M. D.

23B. ADDRESS JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED 12/2/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12-5-49

24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR Mrs. Frances A. Hundley & J. Biddle

ADDRESS 578

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80509

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17 Registered No. G80509

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH M. SIEGRIST

2. DATE OF DEATH Dec. 2. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2849 W. Mulberry

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2849 W. Mulberry St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov 13. 1906 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | at Home | Baltimore Md. | |

13. FATHER'S NAME Ferdinand Bruggeman

14. MOTHER'S MAIDEN NAME Lena Hehrenberg

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | | John L. Siegrist | 2849 W. Mulberry St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast (left) — INTERVAL BETWEEN ONSET AND DEATH: 10 mo

DUE TO

(B) —

DUE TO

(C) —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Feb 15. 1949. | Adeno-carcinoma of breast | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | | — |

22. *I hereby certify that I attended the deceased from* Sept 19 48 *to* Nov 2, 19 49, *that I last saw the deceased alive on* Oct 30, 1949, *and that death occurred at* 7.30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A Colas M. D. | 47 N. Fulton | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 6. 1949 | Western | City - Baltimore - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | Huntington Williams, M.D. | Mrs. Mrs. John W. Teufel & Son | 2311 Edmondson ave |

VS 150

50

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80510

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

754.4

G80510 Registered No.

BIRTH NO. 49-24502

1. NAME OF DECEASED (Type or Print): Karen Elizabeth Schuder

2. DATE OF DEATH: 12/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: 3 wks. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 27-04
D. STREET ADDRESS (If rural, give location): 1577 Stonewood Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | S | 11/11/49 | | | 23 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William D. Schuder
14. MOTHER'S MAIDEN NAME: Elizabeth White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: mother + father ADDRESS: 1577 Stonewood Rd Baltimore Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Congenital heart disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/2/49, 19..., *to* 12/4/, 1949 *that I last saw the deceased alive on* 12/3/, 1949, *and that death occurred at* 4:20 A., *from the causes and on the date stated above.*

23A. SIGNATURE: Charles H. Watt Jr., M. D.
23B. ADDRESS: Union Memorial Hospital
23C. DATE SIGNED: 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/5/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE:
25 FUNERAL DIRECTOR: P. F. Baker & Sons ADDRESS:

VS 150

157E

CAUSE WRITE CLEARLY WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80511

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80511

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY T. SAMSEL

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 625 East 30th Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Atimore
D. STREET ADDRESS (If rural, give location): 625 East 30th Street 9-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Texas, Balto. Co., | |

13. FATHER'S NAME: James Croghan

14. MOTHER'S MAIDEN NAME: (?)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | - | Mrs Marg. Granruth | 625 E. 30th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/23 19 49, to 11/30 19 49, *that I last saw the deceased alive on* 11/30 19 49, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph S. Blum M. D. | 1115 N. Calvert St | 12/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-3-49 | Cathedral | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | [illegible] | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

Js 150

937

If birth certificate is not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80512

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80512

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Julia Watts Hall Johnson

2. DATE OF DEATH: Dec. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 810 Cathedral St.

c. Length of stay in Baltimore: 70 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maryland
D. STREET ADDRESS (If rural, give location): 810 Cathedral St. 11-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | widowed | May 20, 1858 | 91 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Philadelphia | U.S. |

13. FATHER'S NAME: John Penn Brock

14. MOTHER'S MAIDEN NAME: Julia Watts Hall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Robert W. Johnson Jr. | 4E. Madison St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3-4 hrs
DUE TO Congestive Heart Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio-Sclerosis — Gradual
DUE TO myocandetes.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1944, 19__, *to* Dec 3, 1949 *that I last saw the deceased alive on* Dec 3, 1949, *and that death occurred at* 10 1 0 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. H. Moody, M. D. | 1403 Park ave | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-6-1949 | St. Thomas | Garrison Forest Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949

REGISTRAR'S SIGNATURE: Hunter for Williams

25. FUNERAL DIRECTOR — ADDRESS: Henry W. Jenkins&Sons 4905 York Rd.

VS 150

937

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80513 **CERTIFICATE CORRECTED** 1-4-1950 X, 540.0 G80513

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles S. Henderson

2. DATE OF DEATH 12/3/47

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore 50 yrs? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Belair
D. STREET ADDRESS (If rural, give location) 130 x 206

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Feb 19 1890 1891 | 9. AGE (In years last birthday) 57 58 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Market | 10B. KIND OF BUSINESS OR INDUSTRY Lawyer

11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John B Henderson

14. MOTHER'S MAIDEN NAME Ella Martin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) World War I

16. SOCIAL SECURITY NO

17. INFORMANT Patient ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hepatitis, Serum (Transfusion) — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Peptic Ulcer. Hemorrhage from — 4 yrs
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/21/47, 19__, *to* 12/3, 19 47 *that I last saw the deceased alive on* 12/3, 19 47, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Mark Ethell J. M. D. | 23B. ADDRESS 21 Md Hop | 23C. DATE SIGNED 12/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Dec 6 1949 | 24C. NAME OF CEMETERY OR CREMATORY Green Mount Cem | 24D. LOCATION (City, town, or county) (State) Balto., Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1949 | REGISTRAR'S SIGNATURE Christopher Williams, M.D. | 25. FUNERAL DIRECTOR Henry W. Jenkins Sons | ADDRESS 4905 York Rd.

VS 150

117a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-133824

G80514
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80514
Registered No.

1. NAME OF DECEASED (Type or Print): Leonard August Zinck

2. DATE OF DEATH: 12-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1127 Forrest St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single (Div.) | March 2- 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sheet Metal Worker | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Zinck (D | Mary Wenzell (D |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Shock
DUE TO
(B) Ruptured Thoracic Aneurysm
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(over)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-29- , 1949 *to* 12-3- , 1949 *that I last saw the deceased alive on* 12-3- , 1949 *and that death occurred at* 1.50 PM. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Rogers M. D. | Baltimore City Hospitals | 12-4-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5th 1949 | Baltimore | E. North Ave Ext. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 5 1949 | | Lee K. Brook 1703 N. Patterson Park Ave |

VS 150

30D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr The Carthy

G80515

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80515

Registered No. 151

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fred Storath

2. DATE OF DEATH: Dec 1-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2908 Erdman Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 2908 Erdman Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | widowed | June 29-1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Steel Manufacturer | Baltimore Md. | |

13. FATHER'S NAME: Adolph Storath

14. MOTHER'S MAIDEN NAME: Mary Krebs

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, under unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 215-01-9329 | Mrs Wm. Buettan | 2908 Erdman |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of stomach — INTERVAL BETWEEN ONSET AND DEATH: 7 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9/2/49 | Carcinoma stomach with obstruction - | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/13 1949, *to* Dec 1 1949, *that I last saw the deceased alive on* Dec 1 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D. McCarty M. D. | 37 W. Preston St | 12/2/49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/5/49 | New Cathedral | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 DEC 5 - 1949 | | Leonard J. Luck - 5305 | Harford |

VS 150

46B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Harry Glassman
1302 W. Lafayette St.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80516

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Kist

2. DATE OF DEATH: Dec. 2 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1302 W Lexington St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3027 Lenewood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Mar. 28-1864 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Schleicher | |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Anna Wagner | 3027 Lenewood |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardio Vascular disease — ?

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 25, 1949, *to* Dec 2, 1949 *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 8:10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Glassman M. D. | 753 W. Fayette St | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | Pinkington Williams, M.D. | Leonard J. Luck | 5305 Harford |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80517

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

16 Registered No. C80517

1. NAME OF DECEASED (Type or Print): GUSTAV ADOLPH FADUM

2. DATE OF DEATH: Dec. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3320 Richmond Avenue 8-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 9, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stage Manager | Theatre | Baltimore, Maryland | U.S.A. |

13. FATHER'S NAME: Ernest W. Fadum

14. MOTHER'S MAIDEN NAME: Anna E. Sieck

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | none | Mr. Ernest F. Fadum | 4405 N. Charles St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchiogenic Caranoma with metatesis — INTERVAL BETWEEN ONSET AND DEATH: 7 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April 1, 1949 *to* Dec 3, 1949, *that I last saw the deceased alive on* Dec 31, 1949, *and that death occurred at* 7:35 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J Glaser M.D. | 2730 n charles st | 12-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Druid Hill Pk. St. Paul's Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

47c

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80518

BIRTH NO. G80518

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MR CHESTER WILLIAM SNYDER

2. DATE OF DEATH: 12-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEMORIAL HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): STEVENSON
D. STREET ADDRESS (If rural, give location): Hillside Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | JUNE 14, 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| President | Associates, Inc. Chester W. Snyder & | BALTIMORE, MARYLAND | U.S.A. |

13. FATHER'S NAME: ELI SNYDER

14. MOTHER'S MAIDEN NAME: MARY JANE SPANGLER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Grace K. Snyder | Stevenson, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | HEART FAILURE, UREMIA | 1 YEAR |
| DUE TO (B) | ARTERIOSCLEROTIC HEART DISEASE | 4 YEARS |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* NOV 29TH, 1949, *to* DECEMBER 4, 1949, *that I last saw the deceased alive on* DEC 3, 1949, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ray J. Beasley Jr. M. D. | UNION MEMORIAL HOSPITAL | 12-4-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Druid Ridge Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | Hunter Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80519

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80519

1. NAME OF DECEASED (Type or Print): George Howard Walker
2. DATE OF DEATH: Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General (DOA)
c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 10 E. Fort Ave. 23-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | widowed | Oct. 25, 1875 | 74 yrs | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant (Rtd)
10B. KIND OF BUSINESS OR INDUSTRY: Butter & Eggs
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John T. Walker
14. MOTHER'S MAIDEN NAME: Elizabeth McCracken
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Rev. Howard O. Walker ADDRESS: 946 N. George St. York, Pa.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO
(B) Arteriosclerotic Cardio-Vascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammerer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED:

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | Cedar Hill Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80520

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80520

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MARGARET JULIA STRUZIK

2. DATE OF DEATH: 12/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 845 S. KENWOOD AVE

c. Length of stay in Baltimore: 39 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 1-01
D. STREET ADDRESS (If rural, give location): 845 S. KENWOOD AVE.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: JULY 23 1891
9. AGE (In years last birthday): 58 — If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Akain
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT (DAUGHTER) ADDRESS: LILLIAN CHROBOCINSKI SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROTIC CARDIO-VASC. DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 7 YRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) GENERALIZED ARTERIOSCLEROSIS

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

RHEUMATOID ARTHRITIS (GENERALIZED) — 10 YRS.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* MAY 5 1948, *to* DEC. 4, 1949 *that I last saw the deceased alive on* DEC 4, 1949, *and that death occurred at* 3 25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry J. Houghton M. D.
23B. ADDRESS: 333 S. EAST AVE
23C. DATE SIGNED: 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 7-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Gorman Mill Rd

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Geo. L Beyer Jr
ADDRESS: 1512 Holland

VS 150

93C

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G80521

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4/20.0

Registered No. G80521

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lena Salkin

2. DATE OF DEATH: Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: 60 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5018 Denmore Ave. 27-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Jacob

14. MOTHER'S MAIDEN NAME: Dora

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Norman Salkin | 3506 Powhattan Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Heart Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Calcific aortic stenosis — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| RS Fisher | | | Dec. 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-6-49 | Hebrew Young Men | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | | Jack Lewis Inc | 2100 Eutaw Pl |

VS 151

92a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80522 ✓ X 760.5 G80522

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-25820

1. NAME OF DECEASED (Type or Print): Baby Girl Carroway

2. DATE OF DEATH: Nov. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Middle River
D. STREET ADDRESS (If rural, give location): 16 W. Midland Rd. # 20

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | S | Nov. 27, 1949 | | | 5 / 45 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Archie Lee Carraway

14. MOTHER'S MAIDEN NAME: Theda Doris Kicklighter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Theda Carroway, ADDRESS: 16 W. Midland Rd. # 20

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 27, 1949 *to* Nov. 27, 1949 *that I last saw the deceased alive on* Nov. 27, 1949 *and that death occurred at* 11 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Edwin Lewis M. D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: Nov 30 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL DEC 1 1949
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE: Deputy for Commissioner of Health
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

160a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80523

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1605

G80523

Registered No.

BIRTH NO. 49-25821

1. NAME OF DECEASED (Type or Print): Baby Girl Freeman

2. DATE OF DEATH: Nov. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 246 S. Spring Ct. # 31

2-21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | S | Nov. 30, 1949 | | 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Alvin Freeman

14. MOTHER'S MAIDEN NAME: Dorothy Skotarski

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Dorothy Freeman | 246 S. Spring Ct. # 31 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

B Immaturity

DUE TO

A Intracranial hemorrhage

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ✓ NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/30 *, 19*49 *to* 11/30 *, 19*49 *, that I last saw the deceased alive on* 11/30 *, 19*49 *, and that death occurred at* 11:55 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irwin H. Kaiser M.D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL | DEC 1 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

160a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80524

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

40-1

G80524 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia Rose

2. DATE OF DEATH: Dec. 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE MD B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-01

D. STREET ADDRESS (If rural, give location) 1218 St Matthew St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | April 14, 1915 | 34 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | House work | Accomac, Virginia | U.S.A. |

13. FATHER'S NAME: George Blake

14. MOTHER'S MAIDEN NAME: Ebbie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Ebbie Annis | 1218 St. Matthews St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pneumonia Lo | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-1 1949 *to* 12-1 1949, *that I last saw the deceased alive on* 12-4, 1949, *and that death occurred at* 9:45 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | JOHNS HOPKINS HOSPITAL | 12-1-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 7th 1949. | Haw Z East | Accomac, Virginia |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] | J. Edgar Thomas | Accomac, Va |

VS 150

81a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80525

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1-4 G80525

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jeanetter E. Fisher

2. DATE OF DEATH: 12-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1027 Edmondson Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1027 Edmondson Ave.

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 27, 1900
9. AGE (In years last birthday): 49 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hanford Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Gilbert
14. MOTHER'S MAIDEN NAME: Charlotte Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: William Fisher — ADDRESS: 1027 Edmondson

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: 18 months
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 23, 1945 *to* Dec 3, 1949 *that I last saw the deceased alive* Dec 3, 1949 *and that death occurred at* 12:15 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 513 Edmondson Ave
23C. DATE SIGNED: 12/5/49

24A. BURIAL, CREMATION OR REMOVAL (Specify): Burial
24B. DATE: 12-6-1949
24C. NAME OF CEMETERY OR CREMATORY: Magnolia Cem.
24D. LOCATION (City, town, or county) (State): Magnolia Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE: [signature] Wm. J. Williams, M.D.
25. FUNERAL DIRECTOR: Wm Katz & Williams
ADDRESS: 222 N. Lanvale St.

VS 150

46 D

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G80526

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 972.0

G80526 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEO T. (Leroy) Doyle — N-968
2. DATE OF DEATH: 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 2019 Hammond Ferry Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Feb. 26, 1915 | 34 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe fitter
10B. KIND OF BUSINESS OR INDUSTRY: Gas + Elec. Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? /

13. FATHER'S NAME: Bernard C. Doyle
14. MOTHER'S MAIDEN NAME: Mary E. Buckingham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-01-3642
17. INFORMANT — ADDRESS: Mrs. Hilda Doyle, 2221 Ashton St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation due to illuminating gas
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2019 Hammond Ferry Rd
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12/3/49 m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY OCCUR? Gas inhalation by placing head in oven

22. I certify that I took charge of the remains described above, held an Autopsy Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.

23A. SIGNATURE: C. J. Zubrinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑
23C. DATE SIGNED: 12/7/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Baltimore National | 5501 Fredk. Rd. Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR — ADDRESS: Harry K. Nitzke, 4101 Edmondson Ave

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8

163 H

G80527 G80527

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Elizabeth Halley

2. DATE OF DEATH 12/3/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 22 S. Athol ave 28-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W. | Widow | July 27, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Neubauer | — |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | J. Geo Wahl | 22 S. Athol ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| John R Davis M.D. | | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49. | Oak Lawn | Essex. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | | Harry R. Waltze | 4101 Edmondson Ave |

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

937

G80528

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4200 Registered No. G80528

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel Ringgold

2. DATE OF DEATH: 12/2/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 N. Gilmor Street

c. Length of stay in Baltimore: 45-Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 108 N. Gilmor Street 19-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 8/3/1869 | 80 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent Island, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Ella Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Thelma Jones — ADDRESS: 108 N. Gilmor Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Arteriosclerosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/29, 19 49, *to* 12/2, 19 49, *that I last saw the deceased alive on* 11/29, 19 49 *and that death occurred at* 8.40 A. M. *from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.

23B. ADDRESS: 953 Cath[illegible]

23C. DATE SIGNED: 12/3/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/6/49

24C. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Park

24D. LOCATION (City, town, or county) (State): Balto. Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: J. L. Brown & Son — ADDRESS: 109 W. Montgomery St

927

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80529

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

G80529

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Ellen C Schaub

2. DATE OF DEATH: Dec 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 5501 York Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-48
D. STREET ADDRESS (If rural, give location): 5501 York Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Apr 5 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore | |

13. FATHER'S NAME: John M Schaub

14. MOTHER'S MAIDEN NAME: Cath. Cashen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | Miss Schaub | 5501 York Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial infarction | 2 wks |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | Generalized arteriosclerosis | ? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Right hemiplegia | 18 mos. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ✓ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 6, 1946, *to* Dec 3, 1949, *that I last saw the deceased alive on* Dec 2, 1949, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frederick J Vollmer M. D. | 6100 York Road | Dec 5 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] for Williams, M.D. | Rita Wiedefeld | 900 E Biddle St |

VS 150

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80530

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

204.1

G80530

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Anna Marie Best

2. DATE OF DEATH: 12/2/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 134 S. Highland Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | June 30 - 1916 | 33 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | None | Baltimore, Maryland | |

13. FATHER'S NAME: Joseph Matheides

14. MOTHER'S MAIDEN NAME: Mrs. Isabelle Tamon.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Isabelle Stadtlander — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute myeloblastic leukaemia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November 28, 19 49 *to* December 2, 19 49 *that I last saw the deceased alive on* Dec. 2, 19 49 *and that death occurred at* 1:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kaan M. D. | St. Joseph Hospital | 12-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Balto. National Cem. | Frederick Rd. - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | Huntington Williams, M.D. | Edward Connelly | Essex 21, Md. |

VS 150

74a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80531

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

Registered No. G80531

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph H. Moses

2. DATE OF DEATH Dec, 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 2209 Liberty Heights Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug 15, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Merchant | Liquor Business | Baltimore Md | |

13. FATHER'S NAME: Max Moses

14 MOTHER'S MAIDEN NAME: Celia Tramer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes. | W.W. I | | Shirley Moses | 2209 Liberty Heights Ave |

## MEDICAL CERTIFICATION

CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebrovascular hemorrhage | |
| DUE TO (B) | Hypertensive Cardiovascular Disease | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-4, 1949 *to* 12-4, 1949, *that I last saw the deceased alive on* 12-4, 1949, *and that death occurred at* 9 45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Jerome Gober M. D. | Sinai Hosp. | 12/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec, 6, 1949 | Hebrew Washington Rd Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] for Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

VS 150

6

93D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80532
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 880.8 G80532
Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM F. GALVIN — N-961.0
2. DATE OF DEATH November 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Delaware
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilmington
D. STREET ADDRESS (If rural, give location) 2nd and French Sts.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If less than 1 year last birthday) | If under 1 Year Months | Days | If under 24 hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Single | August 11, 1899 | 50 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Crane Operator | Reading R.R. | Philadelphia, Pa. | U.S.A. |

13. FATHER'S NAME: William J. Galvin
14. MOTHER'S MAIDEN NAME: Mary A. McDonnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 197-10-0759
17. INFORMANT — ADDRESS Phila.
Regina A. Mullen 3082 Aramingo Ave Pa

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Methyl Alcohol Poisoning
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Ethyl Alcohol Poisoning
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public place
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) railroad tracks 20/9 Found: Louden Park Cemetery near the
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Found: Nov. 27, 1949 8 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ingestion of methyl alcohol

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Emil H Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Nov. 28, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-5-49 | Sacred Heart Cemetery | 4701 German Hill Rd Balto Co. |

DATE RECEIVED BY LOCAL REGISTRAR DEC 5 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR — ADDRESS Charles S Fiske 901 S. Conkling St.

VS 151

1790

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80533 ✓ G80533

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 10

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) CAROLINE REINHARDT

2. DATE OF DEATH 12/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 435 E. Gittings St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 435 E. Gittings St. 24-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | 6/9/1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home | Germany | |

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Family-Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis — (Interval between onset and death)
DUE TO
(B) arteriosclerosis &
DUE TO
(C) mitral disease of heart

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NO. | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 1948 *to* 12/3/49, 19__, *that I last saw the deceased alive on* 12/3/49, 19__ *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jesse J. McGrath M. D. | 1 E Randall St | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/7/49 | Mount Carmel | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 5 - 1949 | Clayton Williams, M.D. | James L. McCauley - 130 E. Fort Ave. |

VS 150

92 B

Correct age is especially important. If year is unknown, please write the approximate date. Space for each item must be filled.

G80534

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80534

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Gordon Miles

2. DATE OF DEATH 12/1/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp. [illegible]

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 30

c. Length of stay in Baltimore: Life — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 1511 Marshall Street 23-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | July 17, 1925 | 24 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steward | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Albert Miles | Bertha Hollman |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Same — |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/15/49 *to* 12/1/49, 19__, *that I last saw the deceased alive on* 12/1/49, 19__, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Bloch M.D. | Maryland General | 12/1/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 12-6-49 | Glen Haven | Glen Burnie |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 5 - 1949 | [illegible] | James L. McCleary - 130 S. Fort Ave |

VS 150

440

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80535

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20-1 G80535 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Carroll Waldeck
2. DATE OF DEATH: 12/8/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4300 Groveland Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
B. STATE: Md. B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-01
D. STREET ADDRESS (If rural, give location): 4300 Groveland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan. 31 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Electrician | Ltg. Co. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: John W. Waldeck
14. MOTHER'S MAIDEN NAME: Elizabeth L. Johnson.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | — | | Mrs. Rebecca S. Waldeck | 4300 Groveland |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| John R Davis M.D. | | 12/ |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | December 9 1949 | Woodlawn | Woodlawn Balto Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | | Fleming Byers | 5005 Pk Heights |

VS 151

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

be Approved by
a Medical Examiner

✓ X 410

BALTIMORE CITY HEALTH DEPARTMENT #0.1.1 G80536
Registered No. G80536

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sara Cornelia Lenahan
2. DATE OF DEATH: 12-4-49
3. PLACE OF DEATH: A. Baltimore City, Maryland (Dead on Arrival)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Women's Hospital
c. Length of stay in Baltimore: 15 Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elkridge
D. STREET ADDRESS (If rural, give location): 1904 Pine Ave.
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 1, 1909
9. AGE (In years last birthday): 40 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Old Point, Va.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Baulch
14. MOTHER'S MAIDEN NAME: Mary Blanchard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr Kyle S. Lenahan ADDRESS 1904 Pine Ave Elkridge Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mural thrombus of Rt. Ventricle extending through
DUE TO
(B) pulmonic Valve
DUE TO
(C) Rheumatic Heart Disease (not active)
with Mitral Stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

CERTIFICATION APPROVED BY

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): B. Fendall
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?
M. D.
CHIEF OR ASST. MEDICAL EXAMINER

22. *I hereby certify that I attended the deceased from* Feb., 1949 *to* Dec. 3, 1949 *that I last saw the deceased alive on* Dec. 3, 1949, *and that death occurred at* 10:50 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: H. C. Decker M. D.
23B. ADDRESS: Women's Hospital
23C. DATE SIGNED: 12-4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/49
24C. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Pk.
24D. LOCATION (City, town, or county) (State): Washington Rd

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John J. Gordon & Son ADDRESS 9 Wallace St

VS 150

92 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT 490 G80537
Registered No.

# CERTIFICATE OF DEATH

H NO.

1. NAME OF DECEASED (Type or Print): JOSEPH H. HUME

2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital
c. Length of stay in Baltimore: 40 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 129 South Poppleton Street 18-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | divorced | | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Singer Sewing Machine Co. | Virginia | USA |

13. FATHER'S NAME: Benjamin Hume
14. MOTHER'S MAIDEN NAME: Mary Minnick

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Thelma Hume | 42 Poppleton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Lobar Pneumonia | 3 days |
| ANTECEDENT CAUSES | DUE TO | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | Cardiac Decompensation | 2 weeks |
| | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 2, 19__, *to* 12-5-, 1949 *that I last saw the deceased alive on* 12-5-1949, *and that death occurred at* 8:40a *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Louis J. Glorioso M. D. | 2730 N Charles St. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/8/49 | Mt Olivet Cem | 2930 Frederick Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] | John J. Cowan & Son | Hollins St. |

VS 150

108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680538

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680538

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): James Reed | 2. DATE OF DEATH: Dec. 4-1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY: |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore |
| c. Length of stay in Baltimore: 6 Yrs. | D. STREET ADDRESS (If rural, give location): 1019 Leadenhall St. 23-01 |
| 5. SEX: M | 6. COLOR OR RACE: Negro |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH: Dec. 25- 1922 |
| 9. AGE (In years last birthday): 27 | If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY |
| 11. BIRTHPLACE (State or foreign country): Virginia | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: Charles Reed | 14. MOTHER'S MAIDEN NAME: Martha Bailey |
| [illegible] CEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO: 225-18-7883 |
| 17. INFORMANT: Records: | ADDRESS |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous meningitis with paralysis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* 11-15- , 1949, *to* 12-4- , 1949 *that I last saw the deceased alive on* 12-4- , 1949, *and that death occurred at* 6.50 AM, *from the causes and on the date stated above.*

| | | | |
|---|---|---|---|
| 23A. SIGNATURE: [illegible] M. D. | 23B. ADDRESS: Baltimore City Hospitals | 23C. DATE SIGNED: 12-4-1949 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE: 12-8-49 | 24C. NAME OF CEMETERY OR CREMATORY: [illegible] Calary Cemetery | 24D. LOCATION (City, town, or county) (State): Balto. |
| DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949 | REGISTRAR'S SIGNATURE: [illegible] | 25. FUNERAL DIRECTOR: [illegible] Jennings | ADDRESS: 1129 W. Hamburg St. |

VS 150

14

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80539

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 8/2.4

Registered No. G80539

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN VOGT — N-805.2

2. DATE OF DEATH Dec 3 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A - John's Hopkins Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 2939 E. Monument Street 7-01

5. SEX M
6. COLOR OR RACE W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH April 20, 1871
9. AGE (In years last birthday) 78
If Under 1 Year: Months 7, Days 13
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
17. INFORMANT Catherine Keene — ADDRESS 2939 E. Monument St

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MULTIPLE FRACTURES OF SPINE, EXTREMITIES, RIBS and PELVIS — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21A. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) In street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Monument + Potomac Sts.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY Dec. 3 1949 7:15 P.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X
21F. HOW DID INJURY OCCUR? Hit by Automobile while crossing street. 7/1

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, ~~Inspection or Inquiry~~, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Carl Rogen M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER X MEDICAL INVESTIGATOR
23C. DATE SIGNED Dec. 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE December 7, 1949
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) 4430 Blair Road

DATE RECEIVED BY LOCAL REGISTRAR DEC 5 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Frederick D. Miller, Inc. ADDRESS 3019 E. Monument St

VS 151

170C

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. H. Schenrich
1337 E. Chase St.

G80540
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

175 Registered No. G80540

1. NAME OF DECEASED (Type or Print): Josephine B Schuster
2. DATE OF DEATH: Dec 2-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2941 Walbrook Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2941 Walbrook Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Sept 23-1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Baltimore Md | |

13. FATHER'S NAME: Philip Bopp
14. MOTHER'S MAIDEN NAME: Mary Fangmann

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mr. Robert G. Schuster | 2941 Walbrook |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Papillo Cyst-adenocarci-noma - Left ovary.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C) Mural visceral metastases.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Sept 6, 1946 | Generalized abdominal metastasis. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1949 *to* Dec 2, 1949 *that I last saw the deceased alive on* Dec 2, 1949, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hans C. Schenrich M. D. | 1337 E. Chase St. | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/49 | Holy Cross | Brooklyn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5-1949 | | Leonard J. Luck | 5305 Hayford |

VS 150

49a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80541

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80541

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis Howard Frederick

2. DATE OF DEATH: 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. Gen. Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk
D. STREET ADDRESS (If rural, give location): 6816 Holabird Ave.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, (WIDOWED) DIVORCED (Specify)
8. DATE OF BIRTH: March 4 1900
9. AGE (In years last birthday): 49 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Conductor
10B. KIND OF BUSINESS OR INDUSTRY: B&O Railroad
11. BIRTHPLACE (State or foreign country): Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Daniel Frederick
14. MOTHER'S MAIDEN NAME: Mary Scherback
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Louis H. Frederick — ADDRESS: Dundalk Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hodgkins Disease
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/22, 1949, to 12/3, 1949 *that I last saw the deceased alive on* 12/3, 1949, *and that death occurred at* 2 45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William B. Cooper Jr. M. D.
23B. ADDRESS: South Balto Gen. Hosp.
23C. DATE SIGNED: 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Roland L. Fisher — ADDRESS: 2112 Dundalk Ave

VS 150

4413

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80542

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153 Registered No. G80542

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marie Louise Wolfe

2. DATE OF DEATH 12-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland Hospital for the Women of

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Women's Hospital

C. Length of stay in Baltimore 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-10
D. STREET ADDRESS (If rural, give location) 517 E. Cold Spring Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | WIDOWED | Aug. 18, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None. | — | Baltimore, Md. | USA |

13. FATHER'S NAME George Foard

14. MOTHER'S MAIDEN NAME Daisy Cole AHL.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | None | Daisy E Coyne | 2728 Baker St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon with metastatic Abdominal

(B) Lesions

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 8, 1949 *to* Dec. 3, 1949 *that I last saw the deceased alive on* Dec. 3, 1949, *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. C. Decker M. D. | Women's Hospital | 12-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-6-49 | Parkwood | Taylor Ave. Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | Registrar for Williams, MD | G. Howard Strong | 3207 W. North Ave., |

VS 150

46E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80543

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916.0 G80543 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lima Rockwood — N-948-2
2. DATE OF DEATH: Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2617 Francis St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2617 Francis St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2617 Francis St. 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | MARRIED | May 20, | about 50 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Newfoundland | |

13. FATHER'S NAME: Edmund Sooley
14. MOTHER'S MAIDEN NAME: Maria Chislett

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | | | Mr. William Rockwood, Jr. | town Rd. 2283 Riaster |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia - Carbon monoxide poisoning — INTERVAL BETWEEN ONSET AND DEATH: 5-10 min
DUE TO
(B) Extensive burns of entire body.
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 2617 Francis St. |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Dec. 4-49 5:50 A.M. | | Conflagration destroyed home. |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said ~~Autopsy~~, Inspection ✓ Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| Russell L Fraker | | | Dec 4 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | New Cathedral Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

180

G80544
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916 0

Registered No. G80544

1. NAME OF DECEASED (Type or Print): GERALD ROCKWOOD N-948

2. DATE OF DEATH: Dec 4 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2617 Francis St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2617 Francis St. 13-03

5. SEX: M
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 10, 1929
9. AGE (In years last birthday): 20 yrs. If under 1 Year: Months Days. If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofer
10B. KIND OF BUSINESS OR INDUSTRY: Roofing
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wm. Rockwood
14. MOTHER'S MAIDEN NAME: Lima Sooley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World No 2
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Wm. Rockwood, Jr. ADDRESS: 2283 Reisterstown Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia - Carbon Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Extensive Burns of DUE TO Entire Body.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2617 Francis St.
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Dec 4 1949 5:50 A.M.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Conflagration destroyed home

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said* ~~Autopsy~~, *Inspection* + *Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Russell S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12/4/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

180

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80545 ✓ E916.0 G80545

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ERIC ROCKWOOD. N-948. ✓

2. DATE OF DEATH: Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2617 FRANCIS ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2617 Francis St.
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2617 Francis St. 12-03

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.
8. DATE OF BIRTH: Oct. 12, 1931
9. AGE (In years last birthday): 18 yrs. (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofer
10B. KIND OF BUSINESS OR INDUSTRY: Roofing
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Rockwood
14. MOTHER'S MAIDEN NAME: Lima Sooley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): World War No. 2
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. William Rockwood, Jr. ADDRESS: 2283 Reisters town R

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia - Carbon Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH: 5-10 Min.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Extensive Burns of DUE TO Entire Body

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2617 Francis St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 4 1949 5PM
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ✓
21F. HOW DID INJURY OCCUR? Conflagration destroyed home

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said ~~Autopsy~~ Inspection + Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐ suicide ✓, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Russell S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ✓ / ASSISTANT MEDICAL EXAMINER ☐ / MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Dec 4 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

180 ✓

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80546

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80546

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert J. Gardner Sr.

2. DATE OF DEATH: 12/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5220 Cuthbert St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 27-18
D. STREET ADDRESS (If rural, give location): 5220 Cuthbert St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Apr. 1, 1890 | 59 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Vault Attendant | Transit Co. | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Gardner | Susan Houck |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 217-03-1364 | Mrs. A. J. Gardner, Sr. | 5220 Cuthbert Av |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| A. J. Lubinski M.D. | | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/8/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | Curtis G. Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 151

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80547

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80547

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES CLARK LINDSAY

2. DATE OF DEATH: Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 325 E. 30th St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 325 E. 30th St. 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Sept. 9, 1893 | 56 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sales Representative | Oil | Jersey City, N. J. | |

13. FATHER'S NAME: James Clark Lindsay, Sr.

14. MOTHER'S MAIDEN NAME: Jennie Van Benshoeten

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War #1 | | Mrs. Helen S. Lindsay | 325 E. 30th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease — 5 years

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April, 1949, *to* Dec 4, 1949, *that I last saw the deceased alive on* Dec 4, 1949, *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Stephen J Van Lill M. D. | 2243 St Paul St | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | Parkwood Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

Correct age is especially important. If yes, please write the names of these hospitals and nursing homes.

G80548

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E812.4 G80548 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Edgett — N-809-1 — 2. DATE OF DEATH: 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hosp

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3002 E. Monument Street 7-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 9-22-1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pipe fitter | Rustless Steel | New York, N. Y. | |

13. FATHER'S NAME: William Edgett

14. MOTHER'S MAIDEN NAME: Libbie Bishop

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| unknown | | Niel Edgett | Ceres, N. Y. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) multiple fractures — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Monument & Patterson Pk |
|---|---|---|
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: 12-3-49 7½ m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | 21F. HOW DID INJURY OCCUR? Hit by auto while crossing St. 7/1 |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | 12 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12-5-49 | Ceres | New York |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | | WILLIAM COOK, INC. | 1217 St. Paul St. |

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G80549 ✓X

BALTIMORE CITY HEALTH DEPARTMENT 19 G80549

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) LEROY B. HURLEY

2. DATE OF DEATH 12-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Delaware
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Seaford
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | June 1, 1890 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Auto Business | | Delaware | American |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John B Hurley | Dorothea Elsie Elzey |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Unknown | | ? | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Retroperitoneal Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 12 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-3, 1949, *to* 12-5, 1949, *that I last saw the deceased alive on* 12-5, 1949, *and that death occurred at* 11:10 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Eleanor P. Snow M. D. | Union Memorial Hospital | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 10/49 | Odd Fellows Cem | Seaford Del |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | | Wilmot Funeral Home | 2004 Delaware |

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C80550

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80550
Registered No.

BIRTH NO. 49-18444

1. NAME OF DECEASED (Type or Print) WALTER MADREY

2. DATE OF DEATH December 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Franklin Square Hospital

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2442 Paca Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | | Aug. 31, 1949 | | 3 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Md. | |

13. FATHER'S NAME Edward Madrey

14. MOTHER'S MAIDEN NAME Elsie Cole

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Elsie Cole | 2442 E. Paca St. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Undetermined | |
| | DUE TO | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [X].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Carl L Reyer M.D. | | Dec. 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 5, 1949 | Mt Auburn | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | | Mrs Kate R Williams | Schroeder St |

VS 151

200 C

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80551

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80551
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Betty Evans

2. DATE OF DEATH: Dec. 5 '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland (JOHNS HOPKINS HOSPITAL)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Ga.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Athens
D. STREET ADDRESS (If rural, give location): 135 Franklin Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 10-18-09 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| | |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Thos. Evans | Logan Ohio |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis of carotid artery — 3 days
DUE TO (B) Brain tumor — Meningioma of optic chiasm — 4 mos.
DUE TO (C) Extra dural hematoma

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov. 30, 1949 | Meningioma at optic chiasm | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 29, 1949 *to* Dec. 5, 1949 *that I last saw the deceased alive on* Dec. 5, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Maurice L. Silver M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Oak Grove Cem. | Logan Ohio |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | (Handling for Registrar) | John D. Mitchell Home | 1900 Eutaw Place |

VS 150

567

G80552

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80552

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Ball

2. DATE OF DEATH: 12/4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Md. General Hos.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Md. General Hospital
C. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-08
D. STREET ADDRESS (If rural, give location): 261 S. Highland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | single | Jan. 11, 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY: Standard Oil Co. N.J.
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Benjamin E. Bell
14. MOTHER'S MAIDEN NAME: Sarah A. Allen
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Vascular Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R Weis, M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12/5/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-8-49 | Moreland Mem. Park | 5806 Harford Road. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 5 1949
REGISTRAR'S SIGNATURE: Beatrice Williams, Registrar
25. FUNERAL DIRECTOR — ADDRESS: John D. Mitchell Sons 1900 Eutaw Pl.

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correct age is especially important. Physicians please write all names in full and legibly.

G80553

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80553 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John T. Knight

2. DATE OF DEATH: Dec. 3-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3301 Moravia Ave.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3301 Moravia Ave. 27-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | May 20- 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laber | | Balto. Md | U.S.A. |

13. FATHER'S NAME: Jacob Knight

14. MOTHER'S MAIDEN NAME: Sarah L. Walton

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | X | 213-05-8932 | Geo. H. Knight | 1415 Webster St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Heart Disease — 4 years

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 27, 1949, to Dec. 3, 1949, *that I last saw the deceased alive on* December 3/49 *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George Dawyer M. D. | 4808 Harford Rd. | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-6-1949 | Mt. Olivet | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 - 1949 | [illegible] | Flynn + Fleming | 1426 Light St. |

VS 150

937

C80554 ✓ C80554

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZA E. WORRALL

2. DATE OF DEATH: DEC 3, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5011 ROLAND AVE

c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE.
D. STREET ADDRESS (If rural, give location): 5011 ROLAND AVE. 27-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | JUNE 4, 1870 | ABOUT 79 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | - | MARYLAND | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| THOMAS M. DAVIS | UNKNOWN. |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | - | | JASON R. WORRALL | 5011 ROLAND AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Hypertension — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 11 30 - 19[illegible] to 12 2 - 19[illegible], that I last saw the deceased alive on 12 2 - 19[illegible], and that death occurred at 1 10 a m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 3622 Roland Ave | 12-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 6 1949 | St. Marys Hampden | Roland Ave. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | [signature] | Euston E. Donovan | 3818 Roland Ave |

83a

G80555

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 14 Registered No. G80555

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Gussie Rockstroh

2. DATE OF DEATH: 12/4/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION: 1408 Hollins st.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1408 Hollins st. 19-03

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 9/6/1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: School Teacher

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: August Rockstroh
14. MOTHER'S MAIDEN NAME: Minnie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Edith Foss ADDRESS: 7922 Ridgely Oak Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, shock, but the disease, injury or complication which caused death.)
(A) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Rheumatic Endocarditis — ?
DUE TO
(C) Arteriosclerosis — ?

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Year) (Month) (Day) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from Sept 8, 1948, to Dec 3, 1949, that I last saw the deceased alive on Dec. 3, 1949, and that death occurred at 1:15 Am., from the causes and on the date stated above.

23A. SIGNATURE: Carey Rossing M.D.
23B. ADDRESS: 1316 W Lombard St
23C. DATE SIGNED: Dec. 6. 1949

24A. BURIAL, CREMATION, REMOVAL: Burial
24B. DATE: 12/7/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: For Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul st.

92 c

C80556

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80556

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — Wilhelmina Huse

2. DATE OF DEATH — 12/8/49

3. PLACE OF DEATH
A. HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — 1634 Shadyside Rd
Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Balto. 9-02
D. STREET ADDRESS (If rural, give location) — 1634 Shadyside Rd.

5. SEX — Female
6. COLOR OR RACE — White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) — Single
8. DATE OF BIRTH — Jan. 22nd 1871
9. AGE (In years last birthday) — 78
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10. TRADE, PROFESSION OR KIND OF BUSINESS OR INDUSTRY — City of Balto.
11. BIRTHPLACE (State or foreign country) — Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. NAME OF HUSBAND OR WIFE — Joseph R. Huse
14. MOTHER'S MAIDEN NAME — C. Elizabeth Georgas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No)
16. SOCIAL SECURITY NO.
17. INFORMANT — Adolf J. Huse
ADDRESS — 1634 Shadyside Rd.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

PART I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH (Enter only one cause per line for (a), (b), and (c).)

(a) Cardio - Vascular disease — DUE TO

(b) — DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/1, 1949 to 12/7, 1949 that I last saw the deceased alive on 12/6, 1949 and that death occurred at 12:30 m., from the causes and on the date stated above.

23A. SIGNATURE — Joseph R. Liberto, M. D.
23B. ADDRESS — 3508 Bank St. Baltimore 24, Md.
23C. DATE SIGNED — 12/8/49

24A. BURIAL, CREMATION, REMOVAL, OTHER (Specify) — Burial
24B. DATE — 12/7/49
24C. NAME OF CEMETERY OR CREMATORY — London Park
24D. LOCATION (City, town, or county) (State) — Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR — REGISTRAR'S SIGNATURE — Esther Williams, Asst.

25. FUNERAL DIRECTOR — Wm Cook Inc.
ADDRESS — 1217 St. Paul St.

93D

BIRTH NO. 805:57

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80557

1. NAME OF DECEASED (Type or Print): Frederick Dietz

2. DATE OF DEATH: 12- 4- 1949.

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals (4940 Eastern Ave.)
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 525 N. Glover ST.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Jan. 5 -1878
9. AGE (In years last birthday): 71 yrs. (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY: Chauffer
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: C[illegible] Dietz
14. MOTHER'S MAIDEN NAME: Barbara Stutz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C.H. ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Arteriosclerotic Cardio Vascular Disease With Failure
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT SUICIDE HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12- 4- 1949, *to* 12- 4- 1949, *that I last saw the deceased alive on* 12- 4- 1949, *and that death occurred at* 2.40 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: L. A. Cogan M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 12-4-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/7/49
24C. NAME OF CEMETERY OR CREMATORY: Friendship
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 194[illegible]
REGISTRAR'S SIGNATURE: Huntington Williams, Jr.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St

VS 150

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G80558

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 vr. 1 Registered No. G80558

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. VAN DANIKER — Wm. Van Daniker

2. DATE OF DEATH December 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 122 E. 24th Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 122 E. 24th Street 12-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Widowed | 8/24/1879 | 70 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Motorman | Balto. Transit Co. | Colorado | |

13. FATHER'S NAME (Unknown) Van Daniker

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Margaret E. Lefkert | 423 E. 20th St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☑ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George A. Merrill M.D. | | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/9/49 | Parkwood | Parkville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 727 St. Paul St. |

VS 151

937

correct age is especially important. Physicians, please write the cause of death clearly and legibly.

GN. 132715

0559

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80559

1. NAME OF DECEASED (Type or Print): Julia Redd

2. DATE OF DEATH: 12- 3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 710 Brune ST. Z 1 17-03

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug. 27- 1889
9. AGE (In years last birthday): 60 Yrs. (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Wesley Rollins
14. MOTHER'S MAIDEN NAME: Sarah Jane Gilbert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT ADDRESS: B.C.H. Records 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

(B) Hypertensive Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Cerebral Vascular Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10- 15- , 1949, *to* 12- 3- , 1949, *that I last saw the deceased alive on* 12- 3- 1949, *and that death occurred at* 2.40 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: R. A. Cozen M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 12- 4-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-7-49
24C. NAME OF CEMETERY OR CREMATORY: PLEASANT REST
24D. LOCATION (City, town, or county) (State): TOWSON MD.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: William A Cochran
ADDRESS: 916 Penna ave

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937

GK 133943

080560

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Vol. 1 080560 Registered No.

1. NAME OF DECEASED (Type or Print): Frances Mary Adams

2. DATE OF DEATH: 12- 4- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 4 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Gray Manor) Rural Dundalk
D. STREET ADDRESS (If rural, give location): 224 Pinewood Rd. Gray Manor Z 22

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Feb. 13 1903 | 46 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | PA. | |

13. FATHER'S NAME: Frank Petrooski

14. MOTHER'S MAIDEN NAME: Mary Neytek

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Records B.C.H. | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

B.B. Fisher

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12- 4- , 19 49 *to* 12- 4- , 19 49 *that I last saw the deceased alive on* 12- 4- , 1949 *and that death occurred at* 2.00 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Cozen M. D. | B.C.H. 4940 Eastern Ave. | 12-4-49 |

| 24A. BURIAL, ~~CREMATION, REMOVAL (Specify)~~ | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | Sacred Heart | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [illegible] | Wm Cook Inc | 1217 St. Paul St. |

VS 150

~~Approved by the United States Bureau~~

94a

C80561 CERTIFICATE CORRECTED 12-9-49 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. C80561

1. NAME OF DECEASED (Type or Print) BENJAMIN JOHN WIESSNER

2. DATE OF DEATH December 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1805 N. Broadway

c. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1805 N. Broadway

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower

8. DATE OF BIRTH October 7, 1877

9. AGE (In years) last birthday 72 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY Wholesale fish market

11. BIRTHPLACE (State or foreign country) Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin Wiessner

14. MOTHER'S MAIDEN NAME Elizabeth Peppermint

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ~~no~~ Yes (If yes, give war or dates of service) Spanish American

16. SOCIAL SECURITY NO. none

17. INFORMANT ADDRESS 3308 Ramona Avenue - 13 Melvin B. Wiessner

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ARTERIOSCLEROTIC Cardio. Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH 3YRS

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) CHRONIC EMPHYSEMA — 5YRS.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 7, 1946 *to* Dec 4, 1949 *that I last saw the deceased alive on* Dec 4, 1949 *and that death occurred at* 3.30 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE Albert J Hunnefarr. M. D.

23B. ADDRESS 1801 Eutaw Pl

23C. DATE SIGNED 12/5/49.

24A. BURIAL, CREMATION, REMOVAL (Specify) burial

24B. DATE 12/7/49

24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.

24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 937

G80562

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

154

G80562

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET ANNA SCHENK
SHENK, MARGARET

2. DATE OF DEATH DEC. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland SINAI HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Sinai Hospital

C. Length of stay in Baltimore 26 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2601 Oakley Road 27-17

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Married | May 3, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Germany | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Bernard Glaser | ? Babett |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT 2601 Oakley Road ADDRESS |
|---|---|---|
| no | none | Mr. George M. Schenk |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cachexia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Widespread carcinomatosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/15/49 | Ca of recto-sigmoid & widespread metastases | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/8 *1949, to* 12/3, *1949 that I last saw the deceased alive on* 12/3 *1949, and that death occurred at* 7:08 A. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Esteban L. Lacson M.D. | Sinai Hospital | 12/3/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/6/49 | Oak Lawn Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 6 - 1949 | [illegible] Williams, M.D. | HENRY SANDER & SONS, INC. BALTIMORE - 13, MD. |

VS 150

469

Csar

G80563 — BALTIMORE CITY HEALTH DEPARTMENT — G80563

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Csar

2. DATE OF DEATH: Dec-3-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md — B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2826 Kentucky ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 27-0

c. Length of stay in Baltimore: 40 yrs (Yrs. / Mos. / Days)

D. STREET ADDRESS (If rural, give location): 2826 Kentucky Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | married | May 17-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Bohemia | U. S. A. |

13. FATHER'S NAME: John Brambor

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr John Csar | 2826 Kentucky |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Arteriosclerotic cardio Vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1946 *to* Dec. 3, 1949 *that I last saw the deceased alive on* Nov 20, 1949, *and that death occurred at* 5 P m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3400 Eastman Ave. | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 7-49 | Holy Redeemer Cem | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [signature] | J. J. Herr & Son | 3101 Kentucky ave |

VS 150

93D

80564 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 80564

1. NAME OF DECEASED (Type or Print): FRANK EVERET GIBSON

2. DATE OF DEATH: 12/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Montgomery
C. CITY OR TOWN (If outside corporate limits, write R.D. or Rural, and give township): Silver Spring
D. STREET ADDRESS (If rural, give location): 1710 Dublin Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | widowed | Nov. 22, 1873 | 76 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer (rtd) | Railroad | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Glandville Gibson | Emma Hamilton |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mr. Glandville Gibson | Silver Spring 1710 Dublin Dr. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subhepatic abscess — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Common bile duct obstruction
DUE TO
(C) Cholangitis
Diabetes mellitus — years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11/14/49 | Cholecystitis, cholangitis, obstr. common duct | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/3 19 49 *to* 12/5 19 49 *that I last saw the deceased alive on* 12/5 19 49 *and that death occurred at* 1420 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Hawkins Jr. M. D. | Franklin Square Hosp. | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/8/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | Deputy for Indiana, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

127a

G80565 HASTY 43 G80565

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEWIS HASTY
2. DATE OF DEATH: 12-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PROVIDENT HOSPITAL
C. Length of stay in Baltimore: 15 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 11-04
D. STREET ADDRESS (If rural, give location): 1127 MADISON AVENUE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | NEGRO | MARRIED | 12-27-94 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LABORER | CONTRACTING | SOUTH CAROLINA | USA |

13. FATHER'S NAME: SCARVIA HASTY
14. MOTHER'S MAIDEN NAME: CORNELIA JONES

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| UNKNOWN | | CLAYS HASTY | 1127 MADISON AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | SUBARACHNOID HEMORRHAGE | 2 DAYS |
| DUE TO (B) | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE & HYPERTENSION | UNKNOWN |
| DUE TO (C) | PULMONARY EDEMA & CONGESTION | 2 DAYS |

19A. DATE OF OPERATION: NONE
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): NEITHER
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-29-49, to 12-1-49, *that I last saw the deceased alive on* 12-1-49 19____, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. C. Walder | 1514 Dru Sq. Balto Md. | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 6, 1949 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 1949 | Mattie G. Williams, M.D. | Holland Funeral Home | 1601 Druid Hill Ave. 937 |

VS 150

80566

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31 Registered No. 680566

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGIE ELIZABETH THOMPSON

2. DATE OF DEATH December 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
2540 McCulloh Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2540 McCulloh Street 13-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widow | July 23, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | A.A. CO. Md. | U.S.A. |

13. FATHER'S NAME: David Hall

14. MOTHER'S MAIDEN NAME: Serena ??

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Cassie Thompson Brown |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH 2540 McCulloh St.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 4 days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Generalized Arteriosclerosis | 6 mos. |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1, 19 49 *to* Dec 5, 19 49, *that I last saw the deceased alive on* Dec 5, 19 49 *and that death occurred at* 8 A m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2443 Madison Ave | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 8, 1949 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 6 - 1949 | Huntington Williams, MD | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

83a

Dr. Higgins

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

Registered No. C80 22

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BETTIE DeBOSE

2. DATE OF DEATH Dec. 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2545 McCulloh Street

C. Length of stay in Baltimore 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2545 McCulloh Street 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widow | April 10,1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Lynchburg, Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ferdinand Withers | Louise ????? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Samuel P. Williams | 2545 McCulloh St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 2 wks |
| DUE TO (B) | Hypertension | |
| DUE TO (C) | Arteriosclerosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 4, 1949, to Dec 3, 1949, *that I last saw the deceased alive on* Dec 3 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Bradford Higgins M. D. | 2743 Madison Ave | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/1949 | Arbutus Memorial Pk. | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 1949 | Hunington Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave... |

VS 150

83a

C80568

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 17

Registered No. C80568

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | Lillie Smith |
| 2. DATE OF DEATH | Dec. 3-49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 1104 Warner St |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | — |
| C. Length of stay in Baltimore | 12 yrs |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | |
| B. COUNTY | 1104 Warner St |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Balto. |
| D. STREET ADDRESS (If rural, give location) | 1104 Warner St |
| Yrs. Mos. Days | 21-01 |
| 5. SEX | Female |
| 6. COLOR OR RACE | Colored |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | 9-8-1910 |
| 9. AGE (In years last birthday) | 39 |
| If Under 1 Year Months Days | |
| If Under 24 Hours Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | At Home |
| 10B. KIND OF BUSINESS OR INDUSTRY | — |
| 11. BIRTHPLACE (State or foreign country) | Washington D.C. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | John Jordan |
| 14. MOTHER'S MAIDEN NAME | Blanche Hines |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | George Smith 1104 Warner St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Carcinoma Cervix

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* June, 1949 to 12/3, 1949 *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 5:00 P. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| I. Shorofsky M.D. M. D. | 601 N. Monroe St | 12/5/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial | Dec. 8-49 | Mt Calvary |
| 24D. LOCATION (City, town, or county) (State) | | |
| a. a. co md | | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
| DEC 6 - 1949 | | James A Hayes 638 N. Gilmor St |

VS 150

48a

C80569

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 150.0 C80569

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ADARESTA T. POST

2. DATE OF DEATH: Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3930 Belvieu Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3930 Belvieu Ave. 15-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Jan. 30, 1861 | 88 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| School Teacher (rtd) | Dept. Educa. Balto. | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James L. Post | - Mudge |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. J. Ellen Strawbridge | 4400 Fernhill Av. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized arteriosclerosis,

DUE TO Uremia and senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 1946 *to* Dec 4th, 1949 *that I last saw the deceased alive on* Dec 4, 1949, *and that death occurred at* 6 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 3033 W North Ave | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | Green Mount Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [signature] | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

97

0570 BALTIMORE CITY HEALTH DEPARTMENT C80570
BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) MAZIE LEE CARROLL
2. DATE OF DEATH 4 Dec 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Good Samaritan Hosp
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 906 McDonough St 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Single | Sept 20 1906 | 43 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Thomas L. Carroll
14. MOTHER'S MAIDEN NAME Annie ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Palmer Carroll ADDRESS 601 Belnord St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of uterus (cervix)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 Oct, 1949, *to* 4 Dec, 1949 *that I last saw the deceased alive on* 3 Dec, 1949, *and that death occurred at* 7 25 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Emil H. Henning Jr M. D.
23B. ADDRESS 601 Winans Way
23C. DATE SIGNED 5 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Dec 6/49
24C. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
24D. LOCATION (City, town, or county) (State) B. C. County Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Mrs Robert A. Ellison & Daughter ADDRESS 1129 N. Caroline St

VS 150

48B

C80571

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80571

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Arthur William Thorpe**

2. DATE OF DEATH **Dec. 5, 1949**

3. PLACE OF DEATH: A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **2124 MtRoyal Terrace**

c. Length of stay in Baltimore **48** Yrs. ~~XXX~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore,**
D. STREET ADDRESS (If rural, give location) **2124 Mt Royal Terrace,** 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan.8,1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Asst. Mgr. (retired) | Hotel | London, England. | England |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Albert W. Thorpe | Isabel (last name unknown) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | Mrs.AgnesM.Thorpe,2124 Mt Royal Ave., |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Broncho Pneumonia | 3 days. |
| DUE TO | Chronic Myocarditis | 4 yrs. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Generalized Arteriosclerosis | - |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept. 10, 1948, *to* Dec. 5, 1949 *that I last saw the deceased alive on* Dec. 4, 1949, *and that death occurred at* 12:41 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lloyd E. Taylor M. D. | 3902 Greenmount Ave., | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/7/49 | Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 6 - 1949 | | C. Vernon Lemmon. 4611 Park Heights Ave. |

VS 150

937

G80572

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 443 Registered No. G80572

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Michael J. Pelikan

2. DATE OF DEATH Dec. 4/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1733 McHenry St.

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1733 McHenry St. 19-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years, last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Aug. 10, 1906 | 43 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Michael Pelikan | Katherine (Mother) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 217 07 9126 | Mrs. Katherine Ceiner | 1733 McHenry St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) cerebral hemmorrhage | 5 hours |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) hypertensive cardiovascular disease | unKnown |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* Dec. 4, 1949 *to* Dec 4, 1949 *that I last saw the deceased alive on* Dec. 4, 1949, *and that death occurred at* 1.00 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathan Racusin M. D. | 206 S. Gilmor St. | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county, and State) |
|---|---|---|---|
| Burial | 12./ /49 | New Cathedral | 4300 Old Frederick Rd Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | Christopher Williams, M.D. | Harry H. Nitzke | 4101 Edmondson Ave. |

VS 150

93D

Franklin H. Miller ✓

680573

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

680573 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Franklin Miller"

2. DATE OF DEATH: 12/5/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland a. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore – 23

c. Length of stay in Baltimore: Life (Yrs. / Mon. / Days)

D. STREET ADDRESS (If rural, give location): 2477 Frederick Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 6/13/1892 | 57 | – | – |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | Pistorio & Conde Co | Maryland | U.S.A. |

13. FATHER'S NAME: Joseph H. Miller Dec'd

14. MOTHER'S MAIDEN NAME: Elizabeth Libby Dec'd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-18-1753

17. INFORMANT: Elizabeth A. Miller ADDRESS: 2477 Frederick Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage, Left — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Arteriosclerotic Hyp. CVD — ? yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/6/49 *to* 12/5, 1949, *that I last saw the deceased alive on* 12/5, 1949, *and that death occurred at* 2:10 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert J. Lucas M. D. | St. Agnes Hospital | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Entomb. | Dec. 8 - 1949 | Lorraine Park | Woodlawn - Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: F. B. Wippert & Son ADDRESS: 1300 Eutaw Pl

VS 150

937

17

G80574

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 Registered No. G80574

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ALEXANDER S COURSEY

2. DATE OF DEATH 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University of Maryland Hospital.

c. Length of stay in Baltimore Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Halethorpe 27
D. STREET ADDRESS (If rural, give location) 1811 Summit Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White. | married | MAR 7/1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | A & P - TEA - Co | Maryland | U.S.A. |

13. FATHER'S NAME Alexander Coursey

14. MOTHER'S MAIDEN NAME Julia Anne Smith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | ? | 217-01-1126 | Lillian A. Coursey | Same |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Grade IV Congestive Heart Failure | 2 months |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive Cardiovascular Disease DUE TO | Several yrs. |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Uremia | |

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/1/49, 19__, *to* 12/3/49, 19__, *that I last saw the deceased alive on* 12/3, 1949, *and that death occurred at* 10:06 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E Nold, Jr. M. D. | 27 Md Ave | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/1949 | Loudon Pk. Cem. | Balto. Co. - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | | A. B. Wickert & Son | 130 Eutaw Pl. |

VS 150

92D

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

80575 — Registered No. G80575

DEATH NO. Joshua E Pindell

1. NAME OF DECEASED (Type or Print): Joshua E. PINDELL

2. DATE OF DEATH: Dec 4-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital (DOA)

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived if institution: residence before admission)
A. STATE: MARYLAND — B. COUNTY: [redacted]t.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Md 20-03
D. STREET ADDRESS (If rural, give location): 1928 - Hollins - Street.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married. | Sept. 10-1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steam-fitter | | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HARRY Pindell | Eugenia Smith. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 217-01-7515 | Delia C. Pindell | [redacted] Balto. [redacted] Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2-Mos.

DUE TO

(B) Coronary Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy / Inspection or Inquiry) *thereon and from the evidence obtained by said ~~Autopsy~~, Inspection + Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Russell S Frobes M.D. | | 12/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec-7-49 | Loudon Park Cem. A.A. Co. | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [redacted] | H. B. Wright & Son | 1300 Eutaw Pl |

VS 151

94a 12

G80576

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80576

BIRTH NO. 33 Registered No.

1. NAME OF DECEASED (Type or Print) Mary Mc Shane

2. DATE OF DEATH Dec 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission.)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1200 Valley St 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | S | Dec. 23, 1872 | 76 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward Mc Shane

14. MOTHER'S MAIDEN NAME Gabb. McKenna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Sister Superior ADDRESS 1200 Valley St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Post Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio Sclerosis — 5 yrs

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location.)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1 — , 1949, *to* Dec 6 — , 1949, *that I last saw the deceased alive on* Dec 5 , 1949, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23A. SIGNATURE C Gill Hall Wd M. D.

23B. ADDRESS 1631 N North ave

23C. DATE SIGNED Dec 6-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec 7 1949

24C. NAME OF CEMETERY OR CREMATORY Cathedral

24D. LOCATION (City, town, or county) Baltimore (State)

DATE RECEIVED BY LOCAL REGISTRAR DEC 6 - 1949

REGISTRAR'S SIGNATURE Permission for William

25. FUNERAL DIRECTOR Rita Wiedefeld ADDRESS 900 E. Biddle St

VS 150

83B

G80577

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80577

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ellen Agnes O'Donnell

2. DATE OF DEATH: Dec 5-1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 4018 Barrington Rd

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE; b. COUNTY

5. a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md. 15-10

d. STREET ADDRESS (If rural, give location): 4018 Barrington Road

c. Length of stay in Baltimore: 31 yrs - Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | May 12-1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home - | | Centralia Pa | |

13. FATHER'S NAME: Michael Mulligans

14. MOTHER'S MAIDEN NAME: Catherine Coolahan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT. ADDRESS |
|---|---|---|---|
| | | | Katherine A. O'Donnell |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH 4018 Barrington

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bilateral Bronchial Pneumonia | 5 days |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertrophic Arthritis | 2 years. |
| DUE TO | | |
| (C) | Old Age. | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 1, 1937, *to* Dec 5, 1949, *that I last saw the deceased alive on* Dec 6, 1949, *and that death occurred at* 10:25 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harold H Burns M. D. | 529 N. Charles st | Dec 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| | | Saint Ignatius | Centralia Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | | Ellsworth Funeral Home | 5118 Liberty Park Ave 107 |

VS 150

G80578

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

570.3

G80578

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Effie Bradley

2. DATE OF DEATH 12-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 21 0-2
D. STREET ADDRESS (If rural, give location) 2215 Penrose Ave #23

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | 12-23-1891 | 57 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Goodman | Margaret Haddaway |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Benjamin Franklin Bradley | 2215 Penrose Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

1. Intestinal obstruction + gangrene — INTERVAL BETWEEN ONSET AND DEATH: Not known
(A) Esophageal hemorrhage — 1 week
DUE TO Thrombosis of portal and mesenteric veins — ?
(B) Volvulus — ?
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Esophageal varices — 2-3? years
Chronic liver disease - Hepatic insufficiency — 5-6 years
Congestive heart failure - Cirrhosis Terminal

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Cholelithiasis

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-2, 1949, *to* 12-4, 1949 *that I last saw the deceased alive on* 12-4, 1949, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Candler M. D. | Maryland General Hospital | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Dec 6-49 | Sorrame | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6-1949 | | Ellsworth Armacost | 5118 Liberty Park Ave 122 B |

VS 150

G80579
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80579

1. NAME OF DECEASED (Type or Print): Marie Elena Gootee
2. DATE OF DEATH: 12-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland general Hospital
c. Length of stay in Baltimore: 7 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Essex
D. STREET ADDRESS (If rural, give location): 7908 Bridge Avenue #6

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 7-23-42 | 7 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Wilson Gootee
14. MOTHER'S MAIDEN NAME: MARIE MORGERETH
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wilson Gootee ADDRESS: 7908 Bridge Ave. 6.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hemorrhage - diffuse cerebral DUE TO C.V. Clot Subarachnoid hemorrhage — Interval between onset and death: 5 days
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Aplastic anemia DUE TO — 3-4 weeks?
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cachexia Acute congestion

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-26, 1949, to 12-4, 1949, *that I last saw the deceased alive on* 12/4, 1949, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marguerite Louise Candler M. D.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 12-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-7-49.
24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART CEM.
24D. LOCATION (City, town, or county) (State): 4701 GERMAN HILL RD. BALTO CO.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Charles S. Zeller ADDRESS: 901 S. Conkling St.

VS 150

123

G80580

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E81-4 G80580
N-804-2

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Andrew J Lachmann OR Lachman

2. DATE OF DEATH 12/3/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) John Hopkins Hosp.
C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 522 N Potomac St 7-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Jan 4 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shipping Clerk | S-K | Baltimore | U.S.A. |

13. FATHER'S NAME: August Lachman

14. MOTHER'S MAIDEN NAME: Barbara Heis

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | ---- | | Margaret Lachman | 522 N Potomac St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull

DUE TO

(B) Multiple fractures Peritonitis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Street | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Potomac & Monument Sts |
|---|---|---|
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 12/3/49 7:15 p.m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | 21F. HOW DID INJURY OCCUR? Hit while crossing St by auto |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | 4 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 7 1949 | Moreland Park Cemetery | Taylor Ave Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | | Doffel Bros. | 1800 E Lombard St. |

VS 151

170c

G80581

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80581

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Elmer Raley

2. DATE OF DEATH 12-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY St. Mary's
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hollywood
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Jan. 8, 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | | Maryland | U.S.A. |

13. FATHER'S NAME: John Leo Raley

14. MOTHER'S MAIDEN NAME: Elizabeth Goodwin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Hosp. records | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkins disease — DUE TO — Interval between onset and death: 2 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Leucopenia Erythematosus

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* November 28, 1949, *to* December 6, 1949, *that I last saw the deceased alive on* Dec. 6, 1949, *and that death occurred at* 3:27 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clifford T. Riddle Jr. M. D. | Mercy Hospital | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-10-49 | St John's | Hollywood Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [illegible] | P. B. Robinson | Leonardtown Md. |

VS 150

448

C80582

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80582

1. NAME OF DECEASED (Type or Print) JOSEPH LEWIS

2. DATE OF DEATH December 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
3213 Fairfield Road

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3213 Fairfield Road 25-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Married | 10-3-1908 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Shipyard | Richmond Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert Lewis | Mary J. Baker |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 264-14-0979 | Rosa Lewis 3213 Fairfield Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Alcoholism — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Koons M.D. | | Dec. 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Ship | 12-7-1949 | Shocker Chapel | Warrington N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 8 1949 | | Randolph Gallick 1532 E. Biddle St. |

VS 151

77c

BIRTH NO. G80583

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 974.0

Registered No. G80583

1. NAME OF DECEASED (Type or Print): WILLIAM JONES — N-991

2. DATE OF DEATH: December 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 324 Stinson Street 20-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Divorced | March 1904 | 45 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ship yard worker
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fall River, Massachusetts
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Jones
14. MOTHER'S MAIDEN NAME: Mary Fitzpatrick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: William Jones, Jr., ADDRESS: 87 Sevigney Street, Fall River, Mass.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation
DUE TO
(B) Hanging
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 324 Stinson Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Found: Dec. 5, 1949 7.30a m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by necktie from bedpost

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil Kopp M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Dec. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): removal
24B. DATE: 12/6/49
24C. NAME OF CEMETERY OR CREMATORY: Fall River, Mass
24D. LOCATION (City, town, or county) (State): Fall River, Massachusetts

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR ADDRESS: Wm. Cook, Inc., 1217 St. Paul Street

VS 151

164a

Correct age is especially important. Any information given should be accurate.

G80584

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80584 Registered No. 154

1. NAME OF DECEASED (Type or Print) Annie R. Dickerson

2. DATE OF DEATH Dec. 6 - 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1813 E. 28th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1813 E. 28th St.

C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 1813 E. 28th St. B. COUNTY Balto ma
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore md
D. STREET ADDRESS (If rural, give location) 9-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | widowed | June 17 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Pittsburg Pa | U.S.A. |

13. FATHER'S NAME Louis P. Schild

14. MOTHER'S MAIDEN NAME Not Known

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | LeRoy Deceased | 1813 E. 28th St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Rectum — DUE TO — Interval between onset and death: 2 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C) Arteriosclerosis. — 20 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | none | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| No. m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Sept. 1, 1949 *to* Dec. 6, 1949, *that I last saw the deceased alive on* Dec 4, 1949, *and that death occurred at* 4.00 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Willis Stewart M. D. | 6 E. Read St | Dec 6. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/8/49 | Loudon Park | Frederick Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [illegible] | Paul E. Schwartz Jr. | 3615-17 Liberty Ave. |

VS 150

467

G80585

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 ✓ Registered No. G80585

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Fannie E. Bell

2. DATE OF DEATH: Dec. 3, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 521 E. 23d St.

3a. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's

3c. Length of stay in Baltimore: 45 yr. (Yrs. / Mos. / Days: 9 - 08)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F. | W. | Widowed | Dec. 20, 1868 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: B.F. Baldwin

14. MOTHER'S MAIDEN NAME: Elizabeth Hill Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: W.C. Bell ADDRESS: 931 Park Drive, Glassmoor, Ill

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic glomerular nephritis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/20/49, 19__, *to* 12/3/49, 19__, *that I last saw the deceased alive on* 12/3/49 19__, *and that death occurred at* 9 53 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Sworinski M. D. | 1400 N. Caroline St. | 12/4/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | St Johns, Episcopal | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 - 1949 | [illegible] for Williams, M.D. | Chas. J. Evans & Son, Inc. | 118 N. Mt. Royal Ave. 131a |

VS 150

BIRTH NO. 8899

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80586

1. NAME OF DECEASED (Type or Print): Louise Turner

2. DATE OF DEATH: 12-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 100 S. BOND STREET 3-01

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Wid. | Aug. 26, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Elijah Stewart

14. MOTHER'S MAIDEN NAME: Ella Allen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS ADDRESS 4940 EASTERN AV

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Cervix

DUE TO With Abdominal Metastasis

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4, 1949, *to* 12-4, 1949 *that I last saw the deceased alive on* 12-4, 1949 *and that death occurred at* 1:45 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Thorn M. D.

23B. ADDRESS: 4940 EASTERN AVENUE

23C. DATE SIGNED: 12-5-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/9/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem.

24D. [illegible]: Brantly Bros

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Chas O. Wilson ADDRESS 1000 Brantly Ave

VS 150

48a

G80587

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80587

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Mittie A. Adams — 125493

2. DATE OF DEATH: DEC 4 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins Hosp
c. Length of stay in Baltimore: 14 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 25 S. Eden St. 3-01

5. SEX: female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separate
8. DATE OF BIRTH: 8-17-99
9. AGE (In years last birthday): 50
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Camden S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Bram Duford
14. MOTHER'S MAIDEN NAME: Bessie Adam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: George Jones — ADDRESS: 25 S. Bond St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bilateral cerebral thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Diabetes; arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-30-, 1949 *to* 12-4-, 1949 *that I last saw the deceased alive on* 12-4-, 1949, *and that death occurred at* 10 40 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter B. Arms M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 7/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Chas O. Wilson — ADDRESS: 1101 Bentalou Ave

DEC 6 1949

61

80588 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 49

680588 Registered No.

1. NAME OF DECEASED (Type or Print): JOANNE RAMSEY

2. DATE OF DEATH: 12-4-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
c. Length of stay in Baltimore: 4 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALT.
D. STREET ADDRESS (If rural, give location): 810 BRUNSWICK ROAD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | S | 2-3-1945 | 4 YRS. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): NEW YORK
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ARTHUR D. RAMSEY JR.
14. MOTHER'S MAIDEN NAME: ELEANOR EDWARDS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. Arthur Ramsey - 810 Brunswick — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) PULMONARY EDEMA | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) BILATERAL PLEURAL EFFUSION | |
| DUE TO | | |
| | (C) NEPHROSIS | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | ATELECTASIS RT. LUNG | |

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-28 1949 *to* 12-4, 1949 *that I last saw the deceased alive on* 12-4, 1949 *and that death occurred at* 4:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: J A Roberts M. D.
23B. ADDRESS: Mercy Hospital
23C. DATE SIGNED: 12-4-49

24A. BURIAL, CREMATION, REMOVAL: 12/9/49
24B. DATE: 12-7-49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Park
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Leonard J. Luck — ADDRESS: 5305 Harford

VS 150

1336

Royston ✓ X

G80589

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54.4 G80589 Registered No.

BIRTH NO. 49-19825

1. NAME OF DECEASED (Type or Print) Mary Catherine Rayston

2. DATE OF DEATH 12-5-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14, Md. Parkville

c. Length of stay in Baltimore life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 8906 Clement Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 9-2-49 | | 2 | 14 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Balto, Md. | USA |

13. FATHER'S NAME John William Rayston

14. MOTHER'S MAIDEN NAME Rose Clark

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | parent | same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ✓ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 12-3-49, 19__, *to* 12-5-49, 19__, *that I last saw the deceased alive on* 12-5-49, 19__, *and that death occurred at* 9:40 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Green M.D. | Union Memorial Hospital | 12-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-8-49 | Parkwood | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 1949 | Assistant for Williams, M.D. | Leonard J. Luck - 5305 | Wayford |

VS 150

157E

G80590

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80590

1. NAME OF DECEASED (Type or Print): Sr. Mary Gertrude, O.S.F.

2. DATE OF DEATH: December 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 8-01
D. STREET ADDRESS (If rural, give location): Our Lady of Angels Convent, Edison Highway

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Fe. | White | Single | July 18-1891 | 58 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Philadelphia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Andrew Link

14. MOTHER'S MAIDEN NAME: Anna Mohler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sr. of St Francis — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary oedema

DUE TO

(B) Hypertensive Cardio-vascular Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Terminal uraemia

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949, *to* Dec. 6, 1949 *that I last saw the deceased alive on* Dec. 6, 1949, *and that death occurred at* 8:20 A.M.m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Kaan, M. D.

23B. ADDRESS: 1400 N. Caroline Street

23C. DATE SIGNED: 12/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-9-49

24C. NAME OF CEMETERY OR CREMATORY: Glen Riddle

24D. LOCATION (City, town, or county) (State): Pa.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 6- 1949

REGISTRAR'S SIGNATURE: [illegible] for Williams M.D.

25. FUNERAL DIRECTOR: Leonard J. Cusk - 5305 Harford

ADDRESS:

VS 150

937

G80591

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80591

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sr. M. Justiniana, O. S. F.

2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1400 N. Caroline 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | Single | Mar. 21, 1896 | 53 | 8 | 14 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Religious | | Baltimore | |

13. FATHER'S NAME: Henry J. Folker, Sr.

14. MOTHER'S MAIDEN NAME: Helena Halse

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Sister of St. Francis | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage
DUE TO hypertensive cardio-vascular disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Myocardial infarction, old

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 3, 1949, *to* Dec. 5, 1949, *that I last saw the deceased alive on* Dec. 5, 1949, *and that death occurred at* 9:35a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Siwinski M. D. | 1400 N. Caroline St. | Dec. 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-9-49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 1949 | Deputy for Williams, M.D. | Leonard J. Luck | 5305 Harford |

VS 150

93D

G80592

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 20.1

G80592 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laurence Wm. Stevenson

2. DATE OF DEATH Dec. 4 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3016 Mayfield

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-03
D. STREET ADDRESS (If rural, give location) 3016 Mayfield Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | White | married | May 3-1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist | | Pottstown, Penna | |

13. FATHER'S NAME Laurence J. Stevenson

14. MOTHER'S MAIDEN NAME Nellie Trinity

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 213-01-0336 | Mrs. Helen Stevenson | 3016 Mayfield |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 Day |
| DUE TO (B) | Arterial Sclerosis | 5 yrs |
| DUE TO (C) | Chronic Pains | 5 yrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 2, 1949, *to* Dec 4, 1949 *that I last saw the deceased alive on* Dec 4, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. L. Jamesian M. D. | 9450 Harford Rd | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-7-49 | New Cathedral | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 6 1949 | Registrar for Williams, M.D. | Leonard J. Leck | 5305 Harford |

VS 150

944a

G80593

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 443

G80593

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM D. SPRADLIN

2. DATE OF DEATH: 12/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2202 N. Charles St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 7 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 12-06
D. STREET ADDRESS (If rural, give location): 2202 N. Charles St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 10/1/1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mach. | Md. Dry Dock | Va. | |

13. FATHER'S NAME: James

14. MOTHER'S MAIDEN NAME: Cecila Gillespe

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| Yes WW I | | Family - Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 1/2 hr. |
| DUE TO (B) | Hypertension Coder Vas Disease | 8 yrs. |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* April 1947 *to* Dec. 1949 *that I last saw the deceased alive on* Dec. 5th 1949 *and that death occurred at* 12:30 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Kohn M. D. | 1020 Fort Ave | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/8/49 | Cedar Hill | Covington, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 6 1949 | [illegible] | James L. McCue - 130 E. Fort Ave. |

VS 150

93D

680594

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160.0

680594

BIRTH NO. 49-26665 Registered No.

1. NAME OF DECEASED (Type or Print): BABY GIRL KELLY

2. DATE OF DEATH: 11-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 2416 N Harond St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | B | | 11-26-49 | | | | 18 | 48 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | MD. | U.S. |

13. FATHER'S NAME: JAMES — ELLIS

14. MOTHER'S MAIDEN NAME: FRANCES KELLY

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Unknown -
DUE TO possible Cerebral damage
Atelectasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-26, 1949 *to* 11-27, 1949 *that I last saw the deceased alive on* 11-27, 1949 *and that death occurred at* 11 A.M. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hubert K. Pearse M. D. | University H. | 11-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 2 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Deputy for Williams, M.D. | Commissioner of Health | |

VS 150

160a

G80595 ✓ 49 G80595

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-14885

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | RONALD | BLAIR | 2. DATE OF DEATH November 20, 1949 |

| | |
|---|---|
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-02 |
| c. Length of stay in Baltimore — Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location) 819 Greenmount Avenue |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | U | U 7/15/49 | | 4 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| N | K | N K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | T O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Inter-stitial pneumonia | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: ~~natural causes~~ [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl B. Royer M.D. | | 11-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL DEC 5 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | Walter for Williams | Commissioner of Health | |

VS 151

114E ✓

G80596

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80596

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benjamin Jones

2. DATE OF DEATH: Nov. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. 6 Mos. 04 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 411 N. Durham St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Col. | U | U | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| N | K | K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | N O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute congestive cardiac failure

DUE TO

(B) Acute dilatation of heart.

DUE TO

(C) Syphilitic aortitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | 11/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL DEC 5 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

30D

G80597

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No.

G80597

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herman Gordon

2. DATE OF DEATH: 12-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

C. Length of stay in Baltimore: 40 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 6-03
D. STREET ADDRESS (If rural, give location): 200 N. Patterson Park Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Cauc. | W | 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Custom Tailor | | Russia | USA. |

13. FATHER'S NAME: Simon Gordon

14. MOTHER'S MAIDEN NAME: Yetta Steinberg

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Dena Shatenstein | Mitchesville, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 52 hrs.

DUE TO

(B) Cerebral arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-27-49 *to* 12-6-49, *that I last saw the deceased alive on* 12-6, 1949, *and that death occurred at* 9:20 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ruth Bleier M. D. | Sinai Hosp. | 12-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| 12-7-49 | Burial | Bnai Israel Cong. | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | | Sol. Levinson & Bros. | 1124-26 W. North Avenue |

VS 150

83a

80598 Duplicate ✓ 520483

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 150 Registered No. 680598

1. NAME OF DECEASED (Type or Print): Alfredo Silva

2. DATE OF DEATH: Dec 4, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JONES HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-02
D. STREET ADDRESS (If rural, give location) 428 N. trout St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | 2-17-80 | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Portugal
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 186-18-0914
17. INFORMANT: Patient ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of esophagus | 5 wks. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 17, 1949, *to* Dec 4, 1949, *that I last saw the deceased alive on* Dec 4, 1949, *and that death occurred at* 2:45 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: Philip J. Hagley M. D.
23B. ADDRESS: JONES HOPKINS HOSPITAL
23C. DATE SIGNED: Dec. 5, 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/7/49 | Mt Calvary Cem | QA County Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 7 - 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Mrs Robert A. Elliott Daughter ADDRESS: 1129 N. Caroline St.

VS 150

46a

0599 DOLCH ✓ G80599

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 1

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bessie E. Dolch

2. DATE OF DEATH: Dec 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1651 Hanover

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HANOVER St.

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)

A. STATE: Md

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto 23-02

D. STREET ADDRESS (If rural, give location): 1651 Hanover St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | May 5, 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Balto | U S |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| August Schwartz | Augusta — |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | No | Mrs Essie Ault | 1651 Hanover St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — Interval between onset and death: 2 hrs.

DUE TO

(B) Arteriosclerotic Cardio Vascular Disease — 3 Mo.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Oct, 19 49 *to* Dec 5, 19 49, *that I last saw the deceased alive on* Dec 5, 1949, *and that death occurred at* 6 30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G Brenner M. D. | 107 E. West St | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 9, 1949 | London Pk | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Instructor Williams | A. Heard Funeral Co | 1400 Arlington Ave |

VS 150

937

C80600 VS-127491

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80600 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Lory

2. DATE OF DEATH: 11-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: 1 year (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-12
D. STREET ADDRESS (If rural, give location): No Home

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Widowed | March 2, 1892 | 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ben Lory
14. MOTHER'S MAIDEN NAME: Mary Flood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Far advanced pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Luetic cardio-vascular disease

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 3-11- , 1949 *to* 11-29- , 1949, *that I last saw the deceased alive on* 11-29- , 1949, *and that death occurred at* 5:15 A.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. K. Rogers M. D. | B.C.H.--4940 Eastern Ave. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 6 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

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G80601

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80601

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA EPSTEIN

2. DATE OF DEATH: 12-6-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2476 Shirley Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-20; D. STREET ADDRESS (If rural, give location) 3626 Glenayle Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Carmel Home

c. Length of stay in Baltimore: 55 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY:

13. FATHER'S NAME: Abraham

14. MOTHER'S MAIDEN NAME: Celie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mr Jack Levitas ADDRESS: 3626 Glenayle

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C V N D.

DUE TO

(B) Cerebral & Generalized Arteriosclerosis

DUE TO

(C) Cardio. respiratory failure

INTERVAL BETWEEN ONSET AND DEATH: W

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1949 *to* Dec 6 19 49 *that I last saw the deceased alive on* 12/6/49 *and that death occurred at* 1:20 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Leland Greenebaum M. D.

23B. ADDRESS: 2511 Reisterstown Rd

23C. DATE SIGNED: 12/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-7-49

24C. NAME OF CEMETERY OR CREMATORY: Hebrew Rodeph Sholom

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 150

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80602 ✓ No. 1 C80602

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH LOGAN BOOZE, Sr.

2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1810 Kenway Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 27-15

D. STREET ADDRESS (If rural, give location): 1810 Kenway Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Mar. 19, 1892 | 57 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor F. H. A. | U. S. Gov't. | Balto., Md. | |

13. FATHER'S NAME: Joseph L. Booze

14. MOTHER'S MAIDEN NAME: Mary M. Logan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Hilda Booze | Dixon Hill Balto. 9, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion. — INTERVAL BETWEEN ONSET AND DEATH: 6 days.

DUE TO

(B) Coronary sclerosis

DUE TO

(C) Overwright - physical strain

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10 A.M. 12/5, 1949, *to* 8 P.M. 12/5, 1949, *that I last saw the deceased alive on* 12/5, 1949, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D. McCarty M. D. | 37 W. Preston St | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/9/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | WILLIAM J. TICKNER & SONS | Balto., Md. |

VS 150

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80603

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80603

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELLA E. McCULLOUGH

2. DATE OF DEATH: 12/6/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Md. Hospital

c. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-08
D. STREET ADDRESS (If rural, give location): 4203 Eighth Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Divorced | March 27 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | - | Maryland | USA. |

13. FATHER'S NAME: William Engle

14. MOTHER'S MAIDEN NAME: Margaret Cooper

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | - | - | Eva M. Mulligan | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO ARTERIOSCLEROTIC C-V. disease.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebrovascular Accident.
DUE TO

(C) /

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes Mellitus

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 4/30, 19 49 to 12/6, 19 49 that I last saw the deceased alive on 12/6, 19 49, and that death occurred at 3.00 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E. Hall M.D. | U of Md. Hosp. | 12/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Bur 121 | 11-8-49 | Woodlawn Cem | Balto. Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 19[illegible] | [illegible] for Williams, J.P. | Burgee Funeral Home | 3631 Falls Rd |

VS 150

61

G80604 ✓ 420.0 G80604

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Isaac Winfield Stewart

2. DATE OF DEATH: December 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3628 Elm Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): 3628 Elm Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 29, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Night Watchman | Balto. Asphalt Block and Tile | Maryland | U S A |

13. FATHER'S NAME: John Stewart

14. MOTHER'S MAIDEN NAME: Elisa

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 217-07-9824 | Mrs. M. Gertrude Stewart | 3628 Elm Avenue |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arterio-sclerotic heart disease | 1 yr |
| DUE TO (B) | Arterio-sclerotic vascular disease | ? |
| DUE TO (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* Dec 6, 1949, *that I last saw the deceased alive on* Dec 6, 1949, *and that death occurred at* 12:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. N. McFaul Jr. M. D. | 840 W. 36th St | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 9, 1949 | Govans Presbyterian | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | Burgee Funeral Home | 3631 Falls Road |

VS 150

937

80605 ✓ 080605

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 00 ✓

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EZEL McDANIEL

2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): N. 624 Payson Street

C. Length of stay in Baltimore: 9 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 624 N. Payson Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Single | June 21, 1929 | 20 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Drug store | South Carolina | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph McDaniel | Priscilla Canty |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs. Priscilla McDaniel 624 Payson St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pneumonic Phthisis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO
(B) Miliary Tuberculosis of Lungs
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 4, 1949, *to* Dec 5, 1949, *that I last saw the deceased alive on* Dec 5, 1949, *and that death occurred at* 9:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Bradford Higgins M. D. | 2243 Madison Ave | 12-6-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 9, 1949 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

130

G80606

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 17°

Registered No. G80606

1. NAME OF DECEASED (Type or Print): Minnie McCoy Blackford

2. DATE OF DEATH: Dec 5 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4206 Roland ave

C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 4206 Roland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | Jan 19 1875 | 74 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Staunton Va | USA. |

13. FATHER'S NAME: Charles D McCoy

14. MOTHER'S MAIDEN NAME: Minnie Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: L B Johnson ADDRESS: 214 Edgevale Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis (Cerebral type death) — INTERVAL BETWEEN ONSET AND DEATH: 1½ years

DUE TO

(B) Right breast removed May 1945

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| May 1945 | Carcinoma of right breast | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 1949 *to* Dec 5, 1949, *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert B Taylor M. D. | 104 W. Madison St | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 7/49 | Loudon | Balto., Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | Hamilton for Williams, M.D. | Henry Jenkins & Sons | 4905 York Rd. |

VS 150

50

TIFICATE CORRECTED 12/8/49 EHRHARDT ✓ C80607

C80607

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4143

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Esther Ehrhardt

2. DATE OF DEATH December 5, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 8-04
D. STREET ADDRESS (If rural, give location) 2119 E. Mura St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Jan 5, 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md | |

13. FATHER'S NAME William A Smoot

14. MOTHER'S MAIDEN NAME Florence Hayden

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Esther Ehrhardt | 2119 Mura St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral Hemorrhage | 5 hrs. |
| DUE TO (B) | Hypertensive Cardiovascular Disease | 1 yr (?) |
| DUE TO (C) | Lupus Erythematosis (?) | ? |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-5, 1949, *to* 12-5, 1949 *that I last saw the deceased alive on* 12-5, 1949, *and that death occurred at* 5 20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert C. Hartmann, M.D. | JOHNS HOPKINS HOSPITAL | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/9/49 | Baltimore | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | Wilhelm & Dee | 1217 Eutaw St |

VS 150

937

C80608

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 17°

BIRTH NO. C80608 Registered No.

1. NAME OF DECEASED (Type or Print) FLORENCE WHITE

2. DATE OF DEATH December 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-03
D. STREET ADDRESS (If rural, give location) 715 W. Franklin Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | colored | married | Jan. 1, 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Long Island

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Plant

14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Frank White — ADDRESS: 715 W. Franklin St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of breast | several months |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE B. B. Fuller M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Dec. 5, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE 12-7-1949

24C. NAME OF CEMETERY OR CREMATORY: W. W. Calvary Cem.

24D. LOCATION (City, town, or county): Cedar Hill (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 7 - 1949

REGISTRAR'S SIGNATURE: Pennington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. Katie R. Williams & Son

ADDRESS: 522

VS 151

50

G80609

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E983

G80609

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): DAVID REDDICK N-822.9

2. DATE OF DEATH: December 3, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-02
D. STREET ADDRESS (If rural, give location): 1525 W. Lexington Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | March 2, 1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Balto. City | N.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert Reddick | Georgeana Williams |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Arthur Poole | 1633 N Carey St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sodium pentothal poisoning

DUE TO (Administration of anesthesia for operation on fractured jaw) (over)

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Hospital | St. Joseph's Hospital |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] | NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| December 3, 1949 m. | | | Administration of sodium pentothal anesthesia |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-10-1949 | Western Star Cem | Catonsville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Huntington Williams M.D. | Mrs Katie R. Williams | 22 N. Schroeder St. |

VS 151

168

G80610

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 7 3 Registered No. G80610

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lelia Moore

2. DATE OF DEATH: Dec. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 222 N. Fulton Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | | March 31, 1907 | 42. | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Charlotte N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andre Parker

14. MOTHER'S MAIDEN NAME: Lizzie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: James Moore ADDRESS: 222 N. Fulton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive hemothorax

DUE TO Luetic aortitis with aneurysmal dilatation and rupture

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: RS Fraber M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Dec. 6, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-8-1949

24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Miss Katie R. Williams ADDRESS: 322 N. Schroeder St

307

VS 151

G80611 ✓ 601 G80611

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. _____

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Marvin Peacock A71579

2. DATE OF DEATH: DEC 5 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 4-02
D. STREET ADDRESS (If rural, give location): 767 W. Fairmount Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | S. | 1946 | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Md | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Mad Peacock | Sarah Crump |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Sarah Peacock | 767 W. Fairmount Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bilateral Hydronephrosis | ? |
| DUE TO (B) | Obstruction of Vesical Neck | 20 Wks |
| DUE TO (C) | Hypertensive Heart Dis | 1 Wk + |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 7-14- 1949 *to* 12-5- 1949, *that I last saw the deceased alive on* 12-0- 1949, *and that death occurred at* 4:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. C. Robinson M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-9-1949 | Mt. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12-7-1949 | Huntington Williams, M.D. | Wm. Kerr Williams | 322 N. Lanvale St. |

VS 150

133B

G80612 ✓ G80612

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 061

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Williams

2. DATE OF DEATH: 12-3-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 718 W Fayette St "
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 718 W Fayette St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | Cwid | Feb. 10, 1939 | 10 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Med | Med | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Charles Williams

14. MOTHER'S MAIDEN NAME: Alice Lemon.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or probably) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Alice Stukes, 718 W. Fayette St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory paralysis — (INTERVAL BETWEEN ONSET AND DEATH) 1 hours
DUE TO
(B) Tetanus — 2 days
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
Dr. Wm. G. Helfrich
K S Cohen M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident | backyard | rear of 718 W. Fayette Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| October 31, 1949 ? m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | his hand. fell while playing and ran splinter into |

22. *I hereby certify that I attended the deceased from* 12-1, 1949 *to* 12-3, 1949, *that I last saw the deceased alive on* 12-3, 1949, *and that death occurred at* 10P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Nallon M. D. | University Hospital | 12-3-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-8-1949 | Mt. Calvary Cem. | Colesville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | NAME OF FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | | Wm. Slater & Williams | 332 N. Johnson St. |

VS 150

16026-25

12

G80613

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G80613

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JO ANN or JENNIE M. MUNAFO

2. DATE OF DEATH: 12/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL
c. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 1521 Lakeside Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEM. | WHITE | MARRIED | Oct. 11, 1899 | 50. | 1 / 25 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | HOME | U.S. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ANGELO GLORIOSO | Concetta Jeppi |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | | Daughter | same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Dissecting Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: Approx 4 hrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Essential hypertension, severe — DUE TO hypertensive Cardio-Vascular disease

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/5, 1949 *to* 12/5, 1949 *that I last saw the deceased alive on* 12/5, 1949 *and that death occurred at* 12:10 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Ranzoulla M. D. | mercy Hospital | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC. 9-49 | NEW CATHEDRAL | 4300 OLD FREDRICK RD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Pennington Wilson, M.D. | Frank Della Rocca | 322 S. High St. |

VS 150

20 D

G80614

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80614

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carl Frederick Vosloh
2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital (DOA)
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Halethorpe
D. STREET ADDRESS (If rural, give location): 5623 Oregon Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | Aug. 13, 1880 | 69 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Supt. | M. Solomon Iron Co. | Mt. Vernon, Ind | |

13. FATHER'S NAME: Wm. P. Vosloh
14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Carl J. Vosloh, Sr. | 5623 Oregon Ave. Halethorpe, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Accident
DUE TO
(B) Cerebral Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy / Inspection or Inquiry) *thereon and from the evidence, obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Kammer, Jr. M.D. | | Dec. 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/8/49 | Woodlawn, | Woodlawn. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 - 1949 | Thomas Worthington Williams, III | Harry F. Luitzke, | 4101 Edmondson Ave. |

VS 951

83a

G80615

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E90-7 G80615

BIRTH NO. G80615 — Registered No.

1. NAME OF DECEASED (Type or Print): Elizabeth Frost — N-854.0

2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: 8 days (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City
D. STREET ADDRESS (If rural, give location): Old Frederick Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Howard County Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm. Frost | Annie R. Owings |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | No | Tracey Stackhouse, Ellicott City, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subdural hemorrhage
~~XXXXX~~ Lobar pneumonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Hospital | Greene and Lombard St. University Hospital |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 28, 1949 m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Fell out of bed to floor 4/2 |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl R. Rye M.D. | [X] | Dec. 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-8-49 | Mt. View | Alpha, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 7 - 1949 | Huntington Williams, M.D. | F.C. Higinbothom, Ellicott City, Md. |

VS 151

186a

G80616

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80616
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHRISTIAN LARSON

2. DATE OF DEATH: December 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland ~~1600 S. Clinton St.~~

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Medical Dept. Standard Oil Co - Boston Depot

C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-02
D. STREET ADDRESS (If rural, give location): 801 N. Port St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 8, 1886 | 63 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heat Treater

10b. KIND OF BUSINESS OR INDUSTRY: Standard Oil Co.

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Larson

14. MOTHER'S MAIDEN NAME: Mary Wolfert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Crystal Larson, wife, 801 N. Port St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart disease | ? |
| DUE TO (B) | Coronary artery disease | 10/11/49 & 12/6/49 |
| DUE TO (C) | Lobar Pneumonia | 10/31/49 & 12/6/49 |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/3 19 49 *to* 12/6 19 49, *that I last saw the deceased alive on* 12/6 19 49, *and that death occurred at* 11:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Louis J. Kleines M. D.

23b. ADDRESS: 2623 E. Monument St

23c. DATE SIGNED: 12/7/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/9/49

24c. NAME OF CEMETERY OR CREMATORY: Oak Lawn

24d. LOCATION (City, town, or county) (State): Eastern Ave

DATE RECEIVED BY LOCAL REGISTRAR: DEC 7 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

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G80617

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443

G80617

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sassano, Mrs. Eleanor Phillips

2. DATE OF DEATH 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Church Home & Hosp.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Towson - 4
D. STREET ADDRESS (If rural, give location) York & Susquehanna Rds.

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH Dec. 25, 1870 | 9. AGE (In years last birthday) 79 | If under 1 year: Months Days | If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) Baltimore County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Isaac

14. MOTHER'S MAIDEN NAME Eleanor Phillips

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT William Sassano, Tuscany ADDRESS Balto. Apts.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis with subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.

DUE TO

(B) Arteriosclerotic & Hypertensive

DUE TO Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 6, 1949 *to* December 7, 1949, *that I last saw the deceased alive on* Dec. 7, 1949, *and that death occurred at* 6:45 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE Lemon H. Howard M. D.

23B. ADDRESS Church Home Hospital

23C. DATE SIGNED 12-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec-8-49

24C. NAME OF CEMETERY OR CREMATORY Druid Ridge

24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 7 1949

REGISTRAR'S SIGNATURE Inserting for Williams, M.D.

25. FUNERAL DIRECTOR Stewart & Hooven Co. ADDRESS 108 W. North Ave. Balto. 1

937

FORM 150

G80618

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80618 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isabell Calhoun

2. DATE OF DEATH: 12/6/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 500 Potter St
C. Length of stay in Baltimore: Yrs. 3 Mos. Wks. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington D.C
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | married | Aug. 29 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Practical nurse | | Laurel Maryland | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Pritchard | Elizabeth Jamison |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | — | — | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic C.V Disease — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| C. J. Pritchard M.D. | | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/8/49 | Long Hill Cemetery | Laurel, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | Huntington Williams, M.D. | DeWitt Donaldson | Laurel, Md. |

VS 151

93D

304 G80619

G80619

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): John H. Rapp

2. DATE OF DEATH: 12-6-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Sanatorium 600 S. Chapelgate Lane

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 800 West North Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | 2-9-58 | 91 | 10 | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Banking | Maryland | U. S. A. |

13. FATHER'S NAME: Conrad Rapp

14. MOTHER'S MAIDEN NAME: Louise Hiltner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Mrs Dowell 133 Brightside Ave Baltimore, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility c Senile Dementia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Pulmonary Emphysema Bronchopneumonia type unknown — ? 2½ days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 6-3, 1949 *to* 12-6, 1949, *that I last saw the deceased alive on* 12-5-, 1949, *and that death occurred at* 7:31 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M. D. | 2030 W. Fayette St. | 12-6-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-9-1949 | Western Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 5 1949 | Contingent for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

107

G80620

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80620
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE B. SILLS.

2. DATE OF DEATH Dec. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE, MD.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY Hospital

C. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY HARFORD.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BELAIR-
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | MARRIED. | Sept. 5, 1909 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ENGINEER | | HARFORD CO. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| CHARLES S. SILLS | MARTHA HARTZELL |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | GEORGE B. SILLS | BELAIR, MD |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 13 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CARCINOMA - INTESTINAL

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* NOV. 25, 1949 *to* DEC 7, 1949 *that I last saw the deceased alive on* DEC 7, 1949, *and that death occurred at* 12:55 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mary E. Mathews M. D. | Mercy Hospital Baltimore MD. | Dec 7 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-7-49 | St. Marys | Emmorton Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | [illegible] | John O Mitchell & Sons | 1900 Eutaw Pl. |

VS 150

46E

G80621

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-20.0

G80621

Registered No.

1. NAME OF DECEASED (Type or Print): ISAAC ABEL

2. DATE OF DEATH: Dec. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
c. Length of stay in Baltimore: 60 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-12
D. STREET ADDRESS (If rural, give location): 3539 Reisterstown Road

5. SEX: M
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Dec, 1 1874
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Business-
10B. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?: USA.
13. FATHER'S NAME: Morris N. Abel
14. MOTHER'S MAIDEN NAME: Dora ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs Harry Goldman ADDRESS: 3539 Reisterstown Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral anoxia v Palm. Edema — (INTERVAL BETWEEN ONSET AND DEATH) 4-5 hrs
DUE TO
(B) Coronary Thromb. v myocard. infarc. - fr
DUE TO
(C) Arteriosclerotic HT. Dis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-6 1949 *to* 12-6, 1949 *that I last saw the deceased alive on* 12-6, 1949, *and that death occurred at* 10:55 P m. *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph Blocer M. D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 12-6-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-49
24C. NAME OF CEMETERY OR CREMATORY: Shaarei Zion Cong. Cem
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

937

S 06311

# CERTIFICATE CORRECTED 1-20-1950

G80622

G80622

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bernard Davis

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland [redacted] HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 31 Yrs. [redacted] Mos. [redacted] Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-3
D. STREET ADDRESS (If rural, give location): 3631 Liberty Heights Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 8-12-[1897] | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | | Dunn N C | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Lewis Davis | Tobe Rindellwitz |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Jesse Davis | 3631 Liberty Heights |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hodgkin's disease — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) E — DUE TO

(C) Hepatitis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-23-, 1949 *to* 12-7-, 1949 *that I last saw the deceased alive on* 12-7-, 1949, *and that death occurred at* [redacted] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph D. B. King M. D. | [redacted] | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-9-49 | | Portsmouth, Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | Huntington Williams M.D. | Jack Reeves Inc | 2100 Eutaw Pl |

VS 150

44B

G80623

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80623

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MICHAEL DUBICK
2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3510 Lucille Ave
C. Length of stay in Baltimore: 45 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 3510 Lucille Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Operator | Womens Wear | Russia | |

13. FATHER'S NAME: Harry
14. MOTHER'S MAIDEN NAME: Rita

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Sadie Drabeck | 3510 Lucille Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | 2 years |
| DUE TO (B) | Coronary Arteriosclerosis | 3 years |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | diabetes mellitus | ? |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | - | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 6/4/40 *to* 12/7/49, *that I last saw the deceased alive on* 12/1, 1949, *and that death occurred at* 7:—A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Sol Smith M. D. | 1223 E. North Ave | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-8-49 | Dear Israel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | [illegible] Washington Williamsport, Md | Jack Levonke | 2100 Eutaw Pl |

VS 150

61

G80624

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4341.3

G80624

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SIMON PRUCE

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 4613 Park Hgts

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt Sinai Home

C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2635 Loyola Southway

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH:
9. AGE (In years last birthday): 92 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Milk Dealer
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Samuel
14. MOTHER'S MAIDEN NAME: Fagie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Benjamin Pruce ADDRESS: 2635 Loyola So.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac dilatation
DUE TO
(B) Heart Dis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Dec 10 19 49 *to* 12/6 19 49 *that I last saw the deceased alive on* 12/4 19 49 *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: M. Schudeck M.D.
23B. ADDRESS: 2275 Lundy W
23C. DATE SIGNED: 12/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-49
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, town, or county): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

95c

G80625

BIRTH NO. 49-25904

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

163.5

G80625 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Hancock (150009)

2. DATE OF DEATH: November 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. 0 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1337 Pentwood Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | November 26, 1949 | | | | 1 | 3 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Ashley Wade Hancock
14. MOTHER'S MAIDEN NAME: Edith Hoffman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: The Johns Hopkins Hospt. ADDRESS: 601 N. Broadway

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) immaturity — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) and Bacterial Pneumonia

DUE TO

(C) Intrauterine infection

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 26, 19 49 *to* November 26 19 49 *that I last saw the deceased alive on* Nov. 26, 19 49 *and that death occurred at* 9:12 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 601 North Broadway
23C. DATE SIGNED: 11-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: Loch Raven
24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR:
ADDRESS:

VS 150

159

NS--76043
G80626
BIRTH NO.

CERTIFICATE CORRECTED 3-24-50 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

33 ✓

Registered No. G80626

1. NAME OF DECEASED (Type or Print): Maria Hertz J. Hammond

2. DATE OF DEATH: 12-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 329 E. 20th St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | ? ? ? | 80? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| poetess | | Maryland | U.S. |

13. FATHER'S NAME: Charles Hammond

14. MOTHER'S MAIDEN NAME: Julia ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT ADDRESS: Baltimore City Hospitals Records--4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Generalized arteriosclerosis | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 8-12- , 1942, *to* 12-6- , 1949 *that I last saw the deceased alive on* 12-6- , 1949 , *and that death occurred at* 7:45 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. L. Rogers M. D. | B.C.H.--4940 Eastern Ave | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/8/49 | Spring Hill | Easton, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 8 - 1949 | Entries for Williams, MD | John J. Mitchell & Sons, Inc.-1900 Eutaw Place |

VS 150

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G80627 G80627

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) John G. Kempf

2 DATE OF DEATH 12/7/49 12-30 am.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2526 Ashland Ave

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto 7-02

D. STREET ADDRESS (If rural, give location) 2526 Ashland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 8/5/1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Waiter | Anchor Hotel | Germany | |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| (Unknown) Kempf | Mary (Unknown) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 212-18-8090 | Margaret Kempf | 2526 Ashland Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12-4-49

DUE TO

ANTECEDENT CAUSES

(B) Chr. Myocarditis — 5-1-49

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 1 1949, to Dec 7 1949, *that I last saw the deceased alive on* 12-7 1949, *and that death occurred at* 12-30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| William J. Roach M. D. | 501 21 Kenwood Ave | 12/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/10/49 | Woodland Park | Parkville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | Evelyn Williams, M.D. | Wm Cook Inc | 1217 St. Paul St |

VS 150

939

G80628

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

756.7

Registered No. G80628

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sally G. Conway

2. DATE OF DEATH: 12-6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04
D. STREET ADDRESS (If rural, give location): 602 Winans Way

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | 4-30-1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Va. | |

13. FATHER'S NAME: Peter Wood

14. MOTHER'S MAIDEN NAME: Sally Davis

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Ola Hornig | 518 Nottingham Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPOSTATIC PNEUMONIA

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ACUTE CARDIO RESPIRATORY FAILURE

DUE TO

(C) (Other)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/3, 1949 *to* 12/6, 1949 *that I last saw the deceased alive on* 12/6, 1949, *and that death occurred at* 9:55 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Head M.D. | St. Agnes Hosp. | 12/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/10/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | Evelyn Williams, M.D. | Wm. Bok Inc. | 1217 St. Paul St. |

VS 150

123

G80629 G80629

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Dr. 1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Catherine M. Seiler

2. DATE OF DEATH: 7 DEC 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 912 E. North Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 9-08
D. STREET ADDRESS (If rural, give location): 912 E. North Ave

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1/6/1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Pa. | |

13. FATHER'S NAME: Fred Keebler

14. MOTHER'S MAIDEN NAME: Priscilla Egli

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Self | Sullivan 48 Brainard Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 18 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ARTERIOSCLEROTIC C.V.D — 5-10 YRS

DUE TO

(C) HYPERTENSION C.V.D. — 5-10 YRS.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 20 Nov 1949 *to* 7 Dec 1949 *that I last saw the deceased alive on* 6 Dec 1949 *and that death occurred at* 10:50 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R.J. Bauer M.D. | 2270 Park Hill Ave | 7 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/10/49 | Parkwood | Catonsville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | Emerson for Williams, M.D. | [illegible] | [illegible] St. Paul St. |

VS 150

937

G80630 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80630 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Willey

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. 14 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-02
D. STREET ADDRESS (If rural, give location): 2604 McElderry St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 15, 1906 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: Thomas Willey

14. MOTHER'S MAIDEN NAME: Etta Mann

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis, far advanced — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| May-Sept., 1949 | Pulmonary TBC--left | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6-27- 1945 *to* 12-7- 1949, *that I last saw the deceased alive on* 12-7- 1949, *and that death occurred at* 1:00 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| G. S. Rosen M. D. | B.C.H.--4940 Eastern Ave. | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/8/49 | Waynesboro | Waynesboro Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 1949 | Emerson for Williams, M.D. | William Col Son | 1217 St Paul St |

VS 150

136

G80631

BIRTH NO. 49-23786

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

772.0 ✓

Registered No. G80631

1. NAME OF DECEASED (Type or Print): Dwight S. Wilson

2. DATE OF DEATH: 12-5-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 57 Years / Months / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-02
D. STREET ADDRESS (If rural, give location): 107 Bruce St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | M. B. | 10-30-49 | | 1 / 5 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md | |

13. FATHER'S NAME: Ellison Wilson

14. MOTHER'S MAIDEN NAME: Evelyn Swanson 107 Bruce St

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | mother | ✓ |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr Diarrhea

DUE TO

(B) Dehydration - Anemia

DUE TO

(C) Hypo Pulmonia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-30 19 49, *to* 12-5, 19 49 *that I last saw the deceased alive on* 12-5, 19 49, *and that death occurred at* 2 35 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. M. Meekins M. D. | Provident | 12-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-8-1949 | Mt. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | | Mr Kates R Williams | 322 N Lafayette St |

VS 150

1192

G80632

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G80632

1. NAME OF DECEASED (Type or Print): Paul Raymond Edwards

2. DATE OF DEATH: 12-3-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 756 Redwood St.
C. Length of stay in Baltimore: 18 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 4-02
D. STREET ADDRESS (If rural, give location): 756 Redwood St.

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 21-1911
9. AGE (In years) Last birthday: 38
If under 1 Year: Months, Days
If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laboner
10B. KIND OF BUSINESS OR INDUSTRY: Rag Dealer
11. BIRTHPLACE (State or foreign country): A.A. Co. Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ransome Edwards
14. MOTHER'S MAIDEN NAME: Ada Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary Edwards ADDRESS 756 Redwood St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/19/49 *to* 12/3/49, *deceased alive on* 12/3/49, *and that death occurred at* 2 a, m., *from the causes and on the date stated above. I last saw the*

23A. SIGNATURE: David Saunders M. D.
23B. ADDRESS: 1122 N Seven
23C. DATE SIGNED: 12/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-8-1949
24C. NAME OF CEMETERY OR CREMATORY: Severn Md.
24D. LOCATION (City, town, or county) (State): Severn Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, Mgr.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 522 E Lafayette St

VS 150

13B

C80633

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80633

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN H. BOND SR.

2. DATE OF DEATH: 12-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 9 N. LINWOOD AVE.
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 6-01
D. STREET ADDRESS (If rural, give location): 9 N. LINWOOD AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | WIDOWED | 7-28-1873 | 76 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN
10B. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL BOND
14. MOTHER'S MAIDEN NAME: LECRETIA ERHARDT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO: ?
17. INFORMANT: ELIZABETH STAYLOR ADDRESS: SAME

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure
DUE TO
(B) Hemiplegia
DUE TO
(C) Arteriosclerotic cardiovascular renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/5, 1949 *to* 12/8, 1949 *that I last saw the deceased alive on* 12/8, 1949, *and that death occurred at* 4:A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Thorofeh M. D.
23B. ADDRESS: 601 N. Monroe St
23C. DATE SIGNED: 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/10/49
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8-1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: LILLY & ZEILER INC. ADDRESS: BALTO.

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131a

C80634

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80634

BIRTH NO. 49-26850

1. NAME OF DECEASED (Type or Print): Baby girl NOWAKOWSKI

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hospital

c. Length of stay in Baltimore: Yrs. — Mos. — Days 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 6-01
D. STREET ADDRESS (If rural, give location): 2910 E. Baltimore St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | White | Single. | 12-6-49 | | | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Maryland. | U.S.A. |

13. FATHER'S NAME: Walter Nowakowski

14. MOTHER'S MAIDEN NAME: Gertrude Dunnigan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No. (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis, right lung.

DUE TO

(B) Premature infant.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 December 1949 *to* 7 December, 1949, *that I last saw the deceased alive on* 7 December 1949, *and that death occurred at* 9 30 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wayne N. Jacobus, M.D. M. D.

23B. ADDRESS: Church Home & Hospital

23C. DATE SIGNED: 8 December 49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: DEC. 8 1949

24C. NAME OF CEMETERY OR CREMATORY: SACRED HEART

24D. LOCATION (City, town, or county) (State): BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949

REGISTRAR'S SIGNATURE: Printing for Williams, M.D.

25. FUNERAL DIRECTOR: BERNARD DABROWSKI ADDRESS: 2416 E. BALTIMORE ST.

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159

G80635 ✓ G80635

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT B. HARRIS

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pennsylvania Station
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-06
D. STREET ADDRESS (If rural, give location): 2823 N. Howard St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | March 7, 1878 | 71 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Maintenance Engineer | Railroad | Charlottesville, Va. | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Edna M. Harris | 2823 N. Howard St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic cardio-vascular disease | 10 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 23rd, 1949 *to* Dec 7th, 1949 *that I last saw the deceased alive on* Nov 23rd, 1949, *and that death occurred at* 9.00A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert H. Hartley M. D. | PRR Station Baltimore 1 Md. | Dec. 7th '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/10/49 | Highland Cem. | Loch Haven, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| | | WM. J. TICKNER & SONS, Balto., Md. |

VS 150

92D

G80636 | G80636

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): HUGH MCGAINEY (HUGH ANTHONY McGAINEY)

2. DATE OF DEATH: December 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-04
D. STREET ADDRESS (If rural, give location): 637 E. 30th Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Divorced | 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paymaster
10B. KIND OF BUSINESS OR INDUSTRY: Consolated Eng.Co
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James J. McGainey
14. MOTHER'S MAIDEN NAME: Annie Reilly

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): –
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary McCabe ADDRESS: 637 E. 30th Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C.V. Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Carl L Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR
23C. DATE SIGNED: Dec. 7, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-10-49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral
24D. LOCATION (City, town, or county) (State): City

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: WIEDEFELD & SON ADDRESS: GREENMOUNT AVE & 22ND 93

VS 151

C80637

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80637

Registered No.

1. NAME OF DECEASED (Type or Print): Mary Creech

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 720 N. Carey St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | 1895 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at Home
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Columbia . S. C.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Bailey
14. MOTHER'S MAIDEN NAME: Lucy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Uremia | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Carcinoma bladder | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-6, 1949 *to* 12-7, 1949, *that I last saw the deceased alive on* 12-7, 1949, *and that death occurred at* 11:30 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H Hedrick M. D.
23B. ADDRESS: Univ. Hosp.
23C. DATE SIGNED: 12-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 11-49
24C. NAME OF CEMETERY OR CREMATORY: Myers Mills
24D. LOCATION (City, town, or county) (State): South Carolina

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8-1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: James Adams
ADDRESS: 638 N. Gilmor St

VS 150

528

C80638

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 43

C80638

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) PEARL L BOWERS

2. DATE OF DEATH 12/7/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. Gen. Hosp. Baltimore

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16-05
D. STREET ADDRESS (If rural, give location) 930 N Bentalou

5. SEX F | 6. COLOR or RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug 29 1882 | 9. AGE (In years last birthday) 67 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | 10B. KIND OF BUSINESS OR INDUSTRY at Home | 11. BIRTHPLACE (State or foreign country) Baltimore | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME William Duckett | 14. MOTHER'S MAIDEN NAME Catherine Bannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mr William J. Bowers ADDRESS 930 N. Bentalou

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Squamous cell carcinoma of neck

19A. DATE OF OPERATION None | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/22, 194, to 12/7, 194 9, that I last saw the deceased alive on Dec 7 1949, and that death occurred at 2:22 P m., from the causes and on the date stated above.

23A. SIGNATURE E. A. Cravens M. D. | 23B. ADDRESS Md. Gen. Hosp | 23C. DATE SIGNED 12/7/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/10/49 | 24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem | 24D. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR DEC 8 - 1949 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR John J. Lowan & Son | ADDRESS 9 Hollins St. 55E

VS 150

G80639

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

156 1

Registered No. G80639

1. NAME OF DECEASED (Type or Print): Minnie Brown Tolson

2. DATE OF DEATH: Dec 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1026 argyle ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 17-62
D. STREET ADDRESS (If rural, give location): 1026 argyle ave

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: april 3, 1894
9. AGE (In years last birthday): 55
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home wife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Tolson
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: mozilla Carson Howard
ADDRESS: 1026 argyle ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of liver
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 11 months

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Nov 5, 1949 *to* Dec 7, 1949 *that I last saw the deceased alive on* Dec 7, 1949 *and that death occurred at* 2 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: William H Watts M.D.
23B. ADDRESS: Washington
23C. DATE SIGNED: 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/10/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Zion
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Hes. B. Nelson
ADDRESS: 1385 Pennsylvania Ave

VS 150

46F

ENNels ✓

G80640

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80640

1. NAME OF DECEASED (Type or Print): Blanche Ennels

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: 206 Mosher St
B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 14-02
5. STREET ADDRESS (If rural, give location): 706 Mosher St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | M | 4/7/1910 | 39 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H. Wife | at home | Chas. Co | U. S. A. |

13. FATHER'S NAME: Eddie Lavoy
14. MOTHER'S MAIDEN NAME: Cleota Thomas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: none
17. INFORMANT: Paul Ennels ADDRESS: 206 Mosher St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic cardiac failure
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-6-49, 19__, *to* 12-7, 1949 *that I last saw the deceased alive on* 12-7, 1949, *and that death occurred at* 7⁴⁰ A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Fredrick Jr. M. D.
23B. ADDRESS: Hosp
23C. DATE SIGNED: 12-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/10/49
24C. NAME OF CEMETERY OR CREMATORY: Arbutus
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Geo. H. Kelson ADDRESS: 1303 Guilford Av.

VS 150

73C

G80644 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80644 Registered No.

1. NAME OF DECEASED (Type or Print): Savage, Mr. Frank
2. DATE OF DEATH: 12-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home + Hosp.
c. Length of stay in Baltimore: Yrs. 11 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Florida
B. COUNTY: Polk
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lakeland
D. STREET ADDRESS (If rural, give location): 119 N. Ingraham

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: March 4, 1880
9. AGE (In years last birthday): 69
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Railroad Conductor
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Savage, Winfield Scott
14. MOTHER'S MAIDEN NAME: Hines, Mary Lee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Jane Savage ADDRESS: 119 N. Ingraham, Lakeland, Fla.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Active Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 27, 1949 *to* Dec. 8, 1949 *that I last saw the deceased alive on* Dec 8, 1949, *and that death occurred at* 6.30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Kirk Moore M.D.
23B. ADDRESS: Church Home Hospital Baltimore
23C. DATE SIGNED: 12-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: shipped Dec 8-1949
24C. NAME OF CEMETERY OR CREMATORY: League, Texas
24D. LOCATION (City, town, or county) (State): League Texas

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 1949
REGISTRAR'S SIGNATURE: Beatrice Williams
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 St Paul St

VS 150

13B

G80642

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

Registered No. G80642

1. NAME OF DECEASED (Type or Print): JASPER CLAYTON TAYLOR

2. DATE OF DEATH: Dec. 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital, Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-06
D. STREET ADDRESS (If rural, give location): 3213 Alameda Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 3/17/86 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chief Engineer | Seafarer | Md. | USA |

13. FATHER'S NAME: Emory Taylor

14. MOTHER'S MAIDEN NAME: Laura ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | Unknown | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Encephalomalacia of internal capsule | 7 days |
| DUE TO (B) | Hypertensive cardiovascular disease | Unknown |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Pneumonia, lobar, left upper and lower lobes | 3 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 28, 1949 *to* Dec. 5, 1949, *that I last saw the deceased alive on* Dec. 5, 1949 *and that death occurred at* 9:24P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 9/49 | Greenmount | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 9 1949 | Huntington for Williams, M.D. | Welsh Funeral Home 2008 Alameda |

VS 150

108

G80643 ✓ ✗

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

199-8 G80643

BIRTH NO. 8 Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE RULEY
2. DATE OF DEATH: Dec. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: 7 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Rodgers Forge
D. STREET ADDRESS (If rural, give location): 331 Murdock Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 8/15/94 | 55 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bartender | | Md. | USA |

13. FATHER'S NAME: Stephen Ruley
14. MOTHER'S MAIDEN NAME: Anna Bunger

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | Unknown | Records- US Marine Hospital | Balto. Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma involving larynx, lungs, adrenal, primary site undetermined | Unknown |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Cachexia | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* July 18, 1949 *to* Dec. 6, 1949, *that I last saw the deceased alive on* Dec. 6, 1949, *and that death occurred at* 10:14 AM, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. R. Ramey M. D. | US Marine Hospital, Balto, Md. | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/9/49 | Sacred Heart | Sherman Hill Rd. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 8 - 1949 | Huntington Williams, M.D. | John H Connelly | Essex 21, Md. |

VS 150

55E

G80644

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 17 Registered No. G80644

1. NAME OF DECEASED (Type or Print): Hilda Elizabeth Koch
2. DATE OF DEATH: Dec 6-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1729 Cliftview Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-05
D. STREET ADDRESS (If rural, give location): 1729 Cliftview Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 19-1912 | 37 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles Baumgarten
14. MOTHER'S MAIDEN NAME: Mary Anna Nick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr Edward Koch - 1729 Cliftview ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis

DUE TO carcinoma of right breast, with metastasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 9 mos.

19A. DATE OF OPERATION: Apr. 14, 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma, rt. breast with epidermoid metastasis
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 29, 1949, *to* Dec. 6, 1949, *that I last saw the deceased alive on* Dec. 6, 1949, *and that death occurred at* 9:45 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. Paul Higgins, M. D.
23B. ADDRESS: 1414 Eutaw Place
23C. DATE SIGNED: Dec 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/10/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Leonard J. Luck
ADDRESS: 5305 Harford

VS 150

50

G80645 Peake

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1 G80645

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Daniel Leinsz

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3023 Echodale Avenue

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 3023 Echodale Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | Dec. 26, 1861 | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Standard Oil Co | Baltimore, Maryland | |

13. FATHER'S NAME: William Leinsz

14. MOTHER'S MAIDEN NAME: Mary M. Hoffman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Wm. Hall, 3023 Echodale Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-26-, 1949, *to* 12-7-, 1949, *that I last saw the deceased alive on* 12-6-, 1949, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. W. Peake M. D. | 4508 Harford Road | 12-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-10-49 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 8 - 1949 | | Leonard J. Ruck, 5305 Harford Road. |

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C80646

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

171 Registered No. C80646

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CUMMINGS, ESTELLE

2. DATE OF DEATH: 12/5/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland: Baltimore City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt. Md.
D. STREET ADDRESS (If rural, give location): 940 Harlem 16-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Married | 6/2/84 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Chsae Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Cassandra Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Charles E. Cummings
ADDRESS: 940 Harlem Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Cervix | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/30 19 49 *to* 12/5 19 49 *that I last saw the deceased alive on* 12/5 19 49 *and that death occurred at* 9:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Luba K. Holmes M. D.
23B. ADDRESS: Provident Hosp.
23C. DATE SIGNED: 12/6/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-9-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. O. Wilson
ADDRESS: 1000 Brantly Ave

VS 150

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G80647

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80647

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM H. MacKENZIE

2. DATE OF DEATH: December 5, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 3224 Foster Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 3224 Foster Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | December 26, 1874 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | City Fire Dept. | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Hiram MacKenzie

14. MOTHER'S MAIDEN NAME: Emma Holt

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mary E. MacKenzie | 3224 Foster Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemoglyzed arterio sclerosis

DUE TO

(B) Myocardial Degeneration

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 8, 1947 *to* Dec. 5, 1949, *that I last saw the deceased alive on* Nov 17, 1949, *and that death occurred at* 12:55 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ed Flanigan M. M. D. | 3503 Fait ave | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12- 49. | Holy Redeemer Cemetery | 4430 Belair Rd. Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949

REGISTRAR'S SIGNATURE: Huntington for Williams, MD

25. FUNERAL DIRECTOR: Charles D. Zitler, ADDRESS: 901 S. Conkling St. City 2

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G80648 J ✓ 43 G80648

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Ida Simon

2. DATE OF DEATH: Dec 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2700 Classen Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2700 Classen Ave

c. Length of stay in Baltimore: 55 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 2700 Classen Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Isaac Flom
14. MOTHER'S MAIDEN NAME: Sophia Epstein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: David Simon ADDRESS 270 Classen Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage 1 day
DUE TO
(B) Hypertension Cardio-
DUE TO
(C) Vascular disease yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1947, 19—, *to* Dec 7, 1949, *that I last saw the deceased alive on* 12/7, 1949, *and that death occurred at* 7 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm J Beaton M. D.
23B. ADDRESS: 7040 Eden.
23C. DATE SIGNED: 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 9, 1949
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros ADDRESS 1126 W North Ave

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G80649

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G80649

1. NAME OF DECEASED (Type or Print): Nelson E. W. Miller

2. DATE OF DEATH: Dec. 7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1309 E. 36th St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 9-03
D. STREET ADDRESS (If rural, give location): 1309 E. 36th St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 5-1885 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Confectionary
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Edward Miller
14. MOTHER'S MAIDEN NAME: Sarah Grob
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elsie L. Miller ADDRESS: 1309 E. 36th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
(B) ARTERIOSCLEROSIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 22, 19 49 *to* Dec. 7, 19 49 *that I last saw the deceased alive on* Dec. 7 19 49 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Lucat D. Sunday M. D.
23B. ADDRESS: 201 East 33rd St.
23C. DATE SIGNED: Dec. 8-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 10/49
24C. NAME OF CEMETERY OR CREMATORY: Woodland Memorial Pk
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John A. Miller ADDRESS: 2334 Jefferson St.

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G80650

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 3 1

G80650

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Margaret T. Malone

2. DATE OF DEATH: December 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2536 Greenmount Avenue

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2536 Greenmount Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | May 31, 1861 (1865) | 84 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Dominick Regan

14. MOTHER'S MAIDEN NAME: Winifred Hearst Regan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Winiferd Malone ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH 2536 Greenmount Ave.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) CEREBRAL HEMORRHAGE | 6 days. |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949 *to* Dec. 7, 1949, *that I last saw the deceased alive on* Dec. 6, 1949, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry A. Kelly, M. D.

23B. ADDRESS: 2604 St. Paul St.

23C. DATE SIGNED: 12/8/49.

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/9/49 | New Cathedral | 4300 Old Frederick Road |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 - 1949

REGISTRAR'S SIGNATURE: Hunter Williams, M.D.

VS 150 DEC 8 - 1949

25. FUNERAL DIRECTOR ADDRESS: Frederick D. Miller, Inc 3019 E. Monument Street

83a

G80651

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153

G80651

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) James B. Price

2. DATE OF DEATH Dec. 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home And Hospital

c. Length of stay in Baltimore None Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hancock
D. STREET ADDRESS (If rural, give location) High Street.

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan. 5 1882

9. AGE (In years last birthday) 67 If under 1 Year: Months, Days. If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Work

10B. KIND OF BUSINESS OR INDUSTRY Lumber

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Price

14. MOTHER'S MAIDEN NAME Sarah Creek

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT H. Wallace ADDRESS Church Home & Hospital

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: Instant.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Adenocarcinoma Of Colon — 1 yr.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 11/26/49

19B. MAJOR FINDINGS OF OPERATION Adenocarcinoma Of Colon

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949 to Dec. 8, 1949, *that I last saw the deceased alive on* Dec. 8, 1949, *and that death occurred at* 3:05 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE James T. Mumma M. D.

23B. ADDRESS Church Home & Hospital

23C. DATE SIGNED 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12-11-49

24C. NAME OF CEMETERY OR CREMATORY Piney Plains Meth.

24D. LOCATION (City, town, or county) (State) Allegany Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 9 - 1949

REGISTRAR'S SIGNATURE Transcribed for Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Charles R. Bast, Hancock, Md.

VS 150

46E

G80652

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80652 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) C. Carrington Frazier

2. DATE OF DEATH Dec. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1400 N. Lexington St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Aged Women's and Aged Men's Homes
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 14-02
D. STREET ADDRESS (If rural, give location) Baltimore Co.

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH Sept. 16 1868
9. AGE (In years last birthday) 81 — If Under 1 Year: Months 2, Days 21 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY Resident
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joseph F. Frazier
14. MOTHER'S MAIDEN NAME Susan Fryfogle
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT E. H. Reed ADDRESS 1400 N. Lexington St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uremia, Nephro-Sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO
(B) Arteriosclerosis Cardio-vascular disease,
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1949, to December 7, 1949, that I last saw the deceased alive on Dec 6, 1949, and that death occurred at 10 30A m., from the causes and on the date stated above.

23A. SIGNATURE Newland Edward Day M.D.
23B. ADDRESS 4-E-33rd St - 18
23C. DATE SIGNED Dec 8, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/9/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Olive
24D. LOCATION (City, town, or county) (State) Roslyn Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 9 - 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wm. Cook Inc. ADDRESS 127 St. Paul St.

VS 150

131a

LICATE CORRECTED G80653

Devine

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80653

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John T. Devine

2. DATE OF DEATH December 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland (JOHNS HOPKINS HOSPITAL)
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY Cecil
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) North East
D. STREET ADDRESS (If rural, give location)

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 2-16-07
9. AGE (In years last birthday) 42 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME John F. Devine
14. MOTHER'S MAIDEN NAME Annett Vandant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple peripheral emboli — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) myocarditis, type undetermined

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-22, 1949, *to* 12-8, 1949 *that I last saw the deceased alive on* 12-8, 1949, *and that death occurred at* 9:25 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Edward H. Schaemmel, M. D.
23B. ADDRESS JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED 12/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-11-49
24C. NAME OF CEMETERY OR CREMATORY North East Methodist
24D. LOCATION (City, town, or county) (State) North East Cecil Co. Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 9 - 1949
REGISTRAR'S SIGNATURE Acting for Williamson
25. FUNERAL DIRECTOR Joseph P. Grove
ADDRESS North East Md

VS 150

93B

G80654

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

G80654

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Baylin

2. DATE OF DEATH: 12-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3424 Park Heights Ave
C. Length of stay in Baltimore: 43 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 15-12
D. STREET ADDRESS (If rural, give location): 3424 Park Heights Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (If under 1 year—Months, Days; If under 24 hours—Hours, Min.): 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Nathan
14. MOTHER'S MAIDEN NAME: Naomi
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M J Baylin ADDRESS: 2040 Eutaw Place

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(B) Hypertensive C.V.D — ?
DUE TO
(C) Old Healed Necrosis of Uterus — 8 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 19 47 *to* Dec 8 19 49, *that I last saw the deceased alive on* Dec 19 49, *and that death occurred at* 11 15 *a.m., from the causes and on the date stated above.*

23A. SIGNATURE: Chas B Grey M. D.
23B. ADDRESS: 2404 Eutaw Place
23C. DATE SIGNED: Dec 9 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-9-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 - 1949
REGISTRAR'S SIGNATURE: Huntington for Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

937

0655

BIRTH NO. 49-25484

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

77.0

Registered No. 0655

1. NAME OF DECEASED (Type or Print): BABY BOY TAYLOR

2. DATE OF DEATH: December 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 617 ~~North~~ Conway Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | | | | | 5 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Erythroblastosis Fetalis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | [X] | Dec. 3, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL | DEC 8 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1948 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

161 c

G80656
MS--133404

BALTIMORE CITY HEALTH DEPARTMENT 191 G80656
# CERTIFICATE OF DEATH
BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Pete George
2. DATE OF DEATH: 12-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 2 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 3-01
D. STREET ADDRESS (If rural, give location): 1529 Bank Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Separated | Oct. 26, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Greece | |

13. FATHER'S NAME: Hazel George
14. MOTHER'S MAIDEN NAME: Sophia

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Broncho-pneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Myocardial Infarction, Old | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 11-12-, 1949, *to* 12-6-, 1949 *that I last saw the deceased alive on* 12-6- 1949, *and that death occurred at* 2:17 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rogers M. D. | B.C.H.--4940 Eastern Ave. | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Township or County, and State) |
|---|---|---|---|
| Burial | 12-9-49 | Lambros Greek Com. Inc. | 440 E. North Ave Windsor Mill Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Huntington Williams, M.D. | LAMBROS Inc | 440 E. North Ave |

VS 150

107

G80657

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

571:0

G80657

BIRTH NO. 49-08986 Registered No.

1. NAME OF DECEASED (Type or Print) Patricia A. Sobieski

2. DATE OF DEATH Dec 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3505 Kentucky Ave

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 3505 B. COUNTY Kentucky Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-03
D. STREET ADDRESS (If rural, give location) 3505 Kentucky Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | May 3 1949 | | 7 | 5 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edwin J Sobieski
14. MOTHER'S MAIDEN NAME Vivian I Burke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Edwin J Sobieski ADDRESS 3505 Kentucky Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Infectious Diarrhea — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. — 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 Dec 1949, *to* 8 Dec 1949, *that I last saw the deceased alive on* 4 Dec. 1949, *and that death occurred at* 8 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE [illegible] M. D. — 23B. ADDRESS 2900 Dumran — 23C. DATE SIGNED 8 Dec 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 10 1949 | Oak Lawn | Eastern Ave Road |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John C Moran — ADDRESS: 3000 E Baltimore St

VS 150

B. W. SOLLOD

119a

G80658

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0

G80658

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) WILLIAM L. AKINS

2. DATE OF DEATH Dec. 4, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore 159 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Florida
B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Jacksonville Beach

D. STREET ADDRESS (If rural, give location)
138 S. Third Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 4/4/92 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steward | Seafarer | Tenn. | USA |

13. FATHER'S NAME
John Akins

14. MOTHER'S MAIDEN NAME
Rose Mary Minton

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | 264-12-5818 | Records- US Marine Hospital-Balto, Md. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Ruptured esophageal varices | Unknown |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Cirrhosis of liver | Unknown |
| DUE TO | | |
| (C) | Ascites | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* June 28, 1949, *to* Dec. 4, 1949, *that I last saw the deceased alive on* Dec. 4, 1949, *and that death occurred at* 3:20P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson<br>John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/5/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 9-49 | Baltimore Hebrews | Baltimore Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Washington Williams, M.D. | Edwards Amos | 5118 Eastern Ave |

VS 150

1240

G80659

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

143

G80659

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): ALBERT BOWERS HARGETT

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4509 Clifton Rd.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-03
D. STREET ADDRESS (If rural, give location): 4509 Clifton Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 10, 1871 | 78 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Wholesale Meat | Jefferson, Md. | |

13. FATHER'S NAME: Curtis F. Hargett

14. MOTHER'S MAIDEN NAME: Sarah Waskey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Mrs. Elsie A. Hargett | 4509 Clifton Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Hypertensive cardio vascular disease | |
| DUE TO (B) | Myocardial Insufficiency. | |
| DUE TO (C) | | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 3, 1949, *to* Dec, 1949 *that I last saw the deceased alive on* Dec 22 1949, *and that death occurred at* 5A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis T. Levy M. D. | 1844 W. North ave | Dec 8-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/10/49 | Mt. Olivet Cem. | Frederick, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93

G80660

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 4 43 Registered No. G80660

1. NAME OF DECEASED (Type or Print): ROY - RIEDEL

2. DATE OF DEATH: Dec 8. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1533 North Gate Road
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 1533 North Gate Road

c. Length of stay in Baltimore: 56 Yrs. ~~Mos.~~ ~~Days~~

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Sept 23, 1893
9. AGE (In years last birthday): 56 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10B. KIND OF BUSINESS OR INDUSTRY: A & P. Food Store
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Christy Riedel
14. MOTHER'S MAIDEN NAME: Matilda Lysner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): 1st World War
16. SOCIAL SECURITY NO.: 213-05-6223
17. INFORMANT: Emma L. Owens - 1533 North Gate Rd ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 3 days |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive Vascular Disease | 2 Yrs. ? |
| DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 19 47, *to* Dec. 8, 19 49, *that I last saw the deceased alive on* Dec. 7, 19 49, *and that death occurred at* 2 30 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 516 Cathedral St.
23C. DATE SIGNED: 12/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 10 1949
24C. NAME OF CEMETERY OR CREMATORY: Cedar Hill
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mr. Mrs. John W. Teufel - Low 5311 ADDRESS: Edmondson Ave 937

VS 150

G80661

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 90 Registered No. G80661

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stanley Ensey — N-812.0

2. DATE OF DEATH: Dec. 6, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-04; D. STREET ADDRESS (If rural, give location): 2320 Frederick Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widowed | — | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | — | — |

13. FATHER'S NAME: Nathan Ensey

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ernie Sewell — ADDRESS: 428 S Payson St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock due to fracture of mandible

DUE TO — left shoulder, left elbow

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2320 Frederick Ave.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 5, 1949 ? P. m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Fall down cellar steps to floor

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: R S Fraher M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: Dec. 6, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Mt Olivet | Dec. 10th 49 | Mt Olivet Cem | |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: A. Jones — ADDRESS: 501 Wedwood Pkwy

VS 151

186a

S-80661

STATE OF MARYLAND
DEPARTMENT OF POST MORTEM EXAMINERS
OFFICE OF THE CHIEF MEDICAL EXAMINER
700 FLEET STREET
BALTIMORE 2, MARYLAND

~~CHIEF M. D.~~
EXAMINER

December 12, 1949

Mr. John Boyle
Bureau of Vital Statistics
Health Department
Municipal Building
Baltimore 2, Maryland

Re: Stanley Ensey
Died: Dec. 6, 1949

Dear Mr. Boyle:

The death certificate now on file at your office on the above mentioned deceased is incorrect. The following changes should be made:

1. Omit section 21f, "How did injury occur?".
2. Omit section 22, "death resulted from:"

After further investigation it was decided that these items should be left pending court decision.

Your cooperation in correcting this matter will be greatly appreciated.

Very truly yours,

R S Fisher for

Earl L. Royer, M.D.
Ass't. Medical Examiner

emw

AB-133662
G80662

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80562

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ashley Cleland / Holsing

2. DATE OF DEATH: Dec. 7-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 9 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 1309 Maryland Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married (Sep) | July 11-1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Arming Installation | | Pennsylvania | USA |

13. FATHER'S NAME: Holsing (D

14. MOTHER'S MAIDEN NAME: Anne or Anna Kirkpatrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 178-09-3523

17. INFORMANT: Records: ADDRESS: Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchogenic Carcinoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-22- , 1949, *to* 12- 7- , 1949, *that I last saw the deceased alive on* 12- 7- 1949, *and that death occurred at* 2.15PM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | Baltimore City Hospitals | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 10, 1949 | Lorraine Park | Baltimore Co., Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | [illegible] for Williams, M.D. | Burgee Funeral Home | 3631 Falls Road |

VS 150

47c

G80663

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80663

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Kathleen Peters

2. DATE OF DEATH: December 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1301 Park Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mrs. Smith's Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 102 Westtowne Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | M. | Sept. 17, 1904 | 45 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Duties

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Coyne

14. MOTHER'S MAIDEN NAME: Mary Coyne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Walter J. Peters ADDRESS: 1806 Ashburton Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | CAUSE OF DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Carcinomatosis | 3 Mos. |
| DUE TO (B) | Adenocarcinoma of Sigmoid colon | 2 yrs 10 mos |
| (C) | | |

19A. DATE OF OPERATION: Aug 14, 1948

19B. MAJOR FINDINGS OF OPERATION: Obstructing annular carcinoma of sigmoid

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 14 1948 *to* Dec. 8, 1949, *that I last saw the deceased alive on* Dec 8, 1949, *and that death occurred at* 5:20 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.

23B. ADDRESS: 104 West Madison St.

23C. DATE SIGNED: 12/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/12/49

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cem/

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 - 1949

REGISTRAR'S SIGNATURE: [signature] Registrar Williams, M.D.

25. FUNERAL DIRECTOR: Mamie C. Syfer - 1600 W. North Ave.

VS 150

46E

G80664

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80664

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Annie B. Wheeler

2. DATE OF DEATH: December 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3609 Woodbine Ave.
c. Length of stay in Baltimore: 34 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 28-01
D. STREET ADDRESS (If rural, give location): 3609 Woodbine Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | July 6, 1877 | 72 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore, Md. | |

13. FATHER'S NAME: John B. Biemiller

14. MOTHER'S MAIDEN NAME: Annie Riedel

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | 216-03-8992B | Mr. Harry L. Wheeler | 3609 Woodbine Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Cardio vascular disease — several yrs

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Dec 5th, 1949 *to* Dec 7, 1949, *that I last saw the deceased alive on* Dec 7, 1949, *and that death occurred at* 1:20 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. Rowland Kood M. D. | 2200 Garrison Blvd. | 12-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 10, 1949 | Loudon Park Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Huntington Williams, M.D. | Miller & Layman | 4510 Liberty Heights Ave. |

VS 150

939

680665

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80665

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Rachuba

2. DATE OF DEATH: 12/8/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 215 S. Washington St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 2-01

D. STREET ADDRESS (If rural, give location): 215 S. Washington St.

c. Length of stay in Baltimore: 54 Yrs. ~~Mos.~~ ~~Days~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | about 1887 | 62 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Poland | |

13. FATHER'S NAME: John Grzech

14. MOTHER'S MAIDEN NAME: Sophia Zyck

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | George Rachuba | 215 S. Washington St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| William G. Helfrich M.D. | ☐ ☐ | 12/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | St. Stanislaus | Balto. City Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 1949 | Huntington Williams, M.D. | Wm. S. Fialkowski | 2007 Eastern Ave |

VS 151

94a

G80666 BALTIMORE CITY HEALTH DEPARTMENT G80666

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): Irene Clarke

2. DATE OF DEATH: Dec 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 219 Spring Court

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 19 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 219 Spring Court B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-01

D. STREET ADDRESS (If rural, give location) 219 Spring Ct

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widowed | Nov 25-1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Work | | Georgia | U S A |

13. FATHER'S NAME: William Mossman

14. MOTHER'S MAIDEN NAME: Delphine Warlds

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Catherine Marshall | 1437 Webb St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12/5/49

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Pernicious Vomiting — 12/25/49

DUE TO

(C) —

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/1 *,* 19 49 *to* 12/7 *,* 19 49 *, that I last saw the deceased alive on* 12/6 *,* 19 49 *, and that death occurred at* 6 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| T. D. Phifer M. D. | 1422 E. Lord Baltimore 13 | 12/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, or county) (State) |
|---|---|---|---|
| Burial | Dec 12 | Mt. Auburn Cem | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR DEC 9 1949 — REGISTERED [illegible]

25. FUNERAL DIRECTOR: Lattie Gross — ADDRESS: 1408 Ashland Ave

VS 150

94a

CERTIFICATE CORRECTED 12-12-49 ✓ X E8 2 7 G80667

G80667

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mahlon WATTS N-809

2. DATE OF DEATH: December 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Glen Burnie
D. STREET ADDRESS (If rural, give location): 213 Fourth Ave, S.W. ~~Maryland Workshop for the Blind~~

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | ~~Dec.~~ Sept. 3, 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Broom Shop Instructor | Shop For The Blind | Anne Arundel Co. Maryland | U.S.A. |

13. FATHER'S NAME: William Watts

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Julia Martin

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Marian Watts (son) | Glen Burnie Md. |

## CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Multiple fractures | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hemothorax, left | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

MEDICAL CERTIFICATION

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Railroad Station | Glen Burnie R. R. Station, Glen Burnie Maryland |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 9, 1949 6:30 Am. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Backed over by bus |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L Beyer M.D. | | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | Glen Haven | Glen Burnie |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | | Thomas W. Singleton | Glen Burnie |

VS 151

Huntington Williams, M.D.

170C ✓

C80668

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80668

Registered No.

1. NAME OF DECEASED (Type or Print): Anna Mary Appel

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital (DOA)
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04
D. STREET ADDRESS (If rural, give location): 1704 Lemmon St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | June 1, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | none | Germany | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: James E. Morgan — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Wm. H. Kammer, Jr. M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: Dec. 8, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 12/12/49 | Loudon Pk. Crematory | 3801 Fredk Rd. Balto. Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 - 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Henry H. Kirtzle — ADDRESS: 401 Edmondson Ave

931

G80669

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80669 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DANIEL HARRIS

2. DATE OF DEATH: December 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2603 Huron Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2603 Huron Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | May 19. 1893 | 56 | 6 | 16 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Baltimore Annapolis Railroad Co
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? U S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-10-3903
17. INFORMANT: Ella Harris
ADDRESS: 2603 Huron Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adeno-carcinoma of stomach
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: December 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Mount Auburn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore City Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Joseph A. Sisky
ADDRESS: 1619 West Base Street

46B

G80670

BIRTH NO. 49-26616

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80670 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Boy Jakubowski

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-03
D. STREET ADDRESS (If rural, give location): 27 N. Patterson Park Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Dec. 7, 1949 | | | 9 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Chester Jakubowski
14. MOTHER'S MAIDEN NAME: Frances Agnes Kwiatkowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/7/ , 1949, to 12/8/ , 1949, *that I last saw the deceased alive on* 12/8/ , 1949, *and that death occurred at* 8:25 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Joseph Krupa M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/9/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: M. F. Sadowski & Sons
ADDRESS: 1818 Eastern Ave

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G80671 ✓ 43 G80671

BIRTH NO. G80671

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): ANGELA FERRARO
2. DATE OF DEATH: 12-7-'49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital
C. Length of stay in Baltimore: 40 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 8-05
D. STREET ADDRESS (If rural, give location): 2327½ Hartford Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: (illegible) 1878
9. AGE (In years last Birthday): 71. (If under 1 year: Months 3. Days 6. / If under 24 hours: Hours: Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME: Cufanio Ferraro
14. MOTHER'S MAIDEN NAME: Josephine Malanca

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Ferraro ADDRESS: 2327½ Hartford Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure
DUE TO
(B) Hypertensive Arteriosclerotic C-V. Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(?) Bronchopneumonia.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-2 1949 *to* 12-7 1949 *that I last saw the deceased alive on* 12-7 1949 *and that death occurred at* 5.50 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Kaan M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 12/16/1949.
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WENDELL J. DIPPEL ADDRESS: 312 N. Highland Ave 931

G80672 ✓ G80672

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 44 ✓

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LILLY W. SUMAN.

2. DATE OF DEATH: DEC 8 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3623 KESWICK ROAD
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 13-07
D. STREET ADDRESS (If rural, give location): 3623 KESWICK ROAD.

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOW
8. DATE OF BIRTH: MAR 10 1870
9. AGE (In years last birthday): 79 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOSEPH G. GREEN
14. MOTHER'S MAIDEN NAME: MARIE CLEM.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT D. ADDRESS: MRS. IDA D. FISHER - 3623 KESWICK RD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) CARDIO-Renal-Vascular Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: NOV. 22 '49

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-22, 1949 *to* 12-8, 1949 *that I last saw the deceased alive on* Nov 8, 1949, *and that death occurred at* 4:15 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. X. Nelson M. D.
23B. ADDRESS: 617 N. 40th St
23C. DATE SIGNED: 12/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Mar 10/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D. LOCATION (City, town, or county) (State): Frederick, Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Thurston E. Donovan
ADDRESS: 3818 Poland Ave

1310

G80673

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 ✓ G80673

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) KATHERINE GERTRUDE COOK

2. DATE OF DEATH December 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4700 Harford Rd. Harford Nursing Home

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-01
D STREET ADDRESS (If rural, give location) 4218 Springwood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | July 1, 1879 | 70 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Charles Edelman

14 MOTHER'S MAIDEN NAME Annie Verth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO none

17. INFORMANT 4218 Springwood Avenue - Mr. G. Leo Cook

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CEREBRAL THROMBOSIS | 10 DAYS |
| DUE TO | | |
| ANTECEDENT CAUSES (B) | ARTERIAL HYPERTENSION | 15 YRS. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | CEREBRAL ARTERIOSCLEROSIS | 7 YRS. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | HEMIPLEGIA (LEFT) (10-24-47) | 2 YRS. |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/11, 1942 *to* 12/7, 1949, *that I last saw the deceased alive on* 12/7, 1949, *and that death occurred at* 5:50 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE John W Madden M. D. | 23B. ADDRESS 6331 Belair Road (6) | 23C. DATE SIGNED 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial | 24B. DATE 12/10/49 | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery | 24D LOCATION (City, town, or county) Baltimore, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR DEC 9 - 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC. BALTIMORE - 13, MD.

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80674

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

Registered No. C80674

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILMER BRINTON ROGERS

2. DATE OF DEATH: 12-8-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-48

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): Windsor Court Apts C 2 (2111 Garrison Blvd)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 7, 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sec. Treas. | Railroad | Maryland | U.S.A |

13. FATHER'S NAME: John C. Rogers

14. MOTHER'S MAIDEN NAME: Margaret Buckmeyer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War #1 | 705 - 10-9283 | Mrs. Wilmer B. Rogers | 2111 Garrison Blvd |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 2 hours |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive cardiovascular disease | 6 years |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased* ~~from~~ on Dec. 8, 1949 to _____, 19__, *that I last saw the deceased alive on* Dec. 8, 1949, *and that death occurred at* 1 40 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Clifford S. Ruth Jr. M. D. | Mercy Hospital | 12-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

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ES-133841
C80675

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 900.0 C80675
Registered No.

1. NAME OF DECEASED (Type or Print): Mary Kolasinski — N-8540
2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 524 S. Decker Avenue (24)

1-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Wid | Oct. 24, 1874 | 75 (dim) | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or Foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: RECORDS*BALTO. CITY HOSPITALS
ADDRESS: 4940 EASTERN AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Vascular Accident-Right Hemisphere | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Intra Cerebral Hemorrhage-Right Hemisphere | |
| DUE TO | CERTIFICATION APPROVED BY M/ Sulinski M.D. | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cerebral Arteriosclerosis<br>3-Fracture of Left Radius and Ulna | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 524 S. Decker Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): November 30, 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Fell down stairs (inside)

22. *I hereby certify that I attended the deceased from* 11-30 19 49 *to* 12-7- 19 49 *that I last saw the deceased alive on* 12-7 19 49 *and that death occurred at* 7:00 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 12-7-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 12 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary Cem.
24D. LOCATION (City, town, or county) (State): Balto. County

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 - 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John M. Weber
ADDRESS: 401 S. Chester street

VS 150
TO BE APPROVED BY CHIEF MEDICAL EXAMINER.

186a

2 Copies

G80676

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

G80676

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): James Hunt

2. DATE OF DEATH: December 8, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Annapolis
D. STREET ADDRESS (If rural, give location) R.F.D. # 2, Box 400

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | U.S.A. | |

13. FATHER'S NAME: James D. Hunt

14. MOTHER'S MAIDEN NAME: Charlotte Henson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | James H. Hunt | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 hours.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ✓ NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-5, 1949 *to* 12-8, 1949 *that I last saw the deceased alive on* 12-5, 1949, *and that death occurred at* 8 52 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip D. Wagley M.D. | JOHNS HOPKINS HOSPITAL | Dec. 9, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 11 1949 | Broadneck | St. Margrets A.A.Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Huntington Williams, M.D. | F.B. Johnson | Annapolis Md |

VS 150

830a

2746 Alameda

Dr. Edmonds

G80677

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80677

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sarah E. Meushaw

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Snyder's Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-07
D. STREET ADDRESS (If rural, give location): 1602 Gorsuch Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| femal e | white | widowed | Sept. 7, 1855 | 94 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Hill

14. MOTHER'S MAIDEN NAME: Margaret ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs' Catherine Peters, ADDRESS: 639 Woodington

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

(B) Arterio sclerotic Cardio Vascular Disease — 5 Jan-46

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5-January, 1946 *to* 7-Dec, 1949, *that I last saw the deceased alive on* 6-Dec, 1949 *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas W Edwards M. D. | 2746 Ave Alameda | 9-Dec-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-10-49 | New Cathedral | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 - 1949

REGISTRAR'S SIGNATURE: Huntington for Williams, Jr. M.D.

25 FUNERAL DIRECTOR: Leonard J. Ruck ADDRESS: 5305 Harford Road

VS 150

937

G80678

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80678

1. NAME OF DECEASED (Type or Print): Alverta Simmons

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 26-03
D. STREET ADDRESS (If rural, give location): 3131 Chesterfield Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | 8-30-1903 | 46 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | md. | |

13. FATHER'S NAME: John Eaton

14. MOTHER'S MAIDEN NAME: Margaret Schwab

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Bernard Simmons | same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemorrhage | 12-14 hrs. |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive CVD | ? yrs. |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/1 1949 *to* 12/8 1949, *that I last saw the deceased alive on* 12/9 1949, *and that death occurred at* 6 50 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert A. Lerches M.D. | St. Agnes Hospital | 12/8/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 12-49 | Loraine Pk. Cem. | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 - 1949 | Huntington Williams, M.D. | John A. Miller | 2334 Jefferson Ave |

VS 150

93)

G80679 G80679

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 6 10 Registered No.

1. NAME OF DECEASED (Type or Print): VACLAV PRUCHA
2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH'S HOSPITAL
c. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 7-02
D. STREET ADDRESS (If rural, give location): 830 N. KENWOOD AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | WIDOWER | 7-15-1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HELPER | ? | CZECHOSLOVAKIA | |

13. FATHER'S NAME: Vaclav Prucha
14. MOTHER'S MAIDEN NAME: Johanna —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 215-22-9135
17. INFORMANT: Clement Prucha ADDRESS: 830 N. Kenwood

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Several hours
DUE TO
(B) Arteriosclerosis
DUE TO
(C) Hypertension

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Benign prostatic hypertrophy

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-7-49 | Rt. hydrocele - benign prostatic hypertrophy | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-19 , 1949 *to* 12-7 , 1949 *that I last saw the deceased alive on* 12-7 , 1949 *and that death occurred at* 10 55 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Joseph Krejci M. D. | 1400 N. Caroline St. | 12-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 9 1949 | Hunter Williams, M.D. | Frank Grachon Son | 900 Edmonton |

137a

C80680

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

590 Registered No. C80680

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louisa Morton

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3207 Barclay St

C. Length of stay in Baltimore: 30 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 12-02
D. STREET ADDRESS (If rural, give location): 3207 Barclay St

5. SEX: F
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): W
8. DATE OF BIRTH: Jan. 1879
9. AGE (In years last birthday): 70
If under 1 year: Months / Days
If under 24 hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Longgreen Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:

17. INFORMANT: Emma Harvey ADDRESS: 310 Lemmon Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

DUE TO

(B) Arteriosclerosis

DUE TO

(C) Acute nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1949 *to* Dec 7, 1949, *that I last saw the deceased alive on* Dec 6, 1949, *and that death occurred at* 4 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Dave A Johnson M. D.
23B. ADDRESS: 2329 Guilford Ave
23C. DATE SIGNED: Dec 9 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-10-49
24C. NAME OF CEMETERY OR CREMATORY: Pleasant Rest
24D. LOCATION (City, town, or county) (State): Towson Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 8 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Byrant & Mamie Wright ADDRESS: 83a 721 Augusta St

G80681

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80681

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): JOHN JOSEPH BYRNE, Sr.

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2002 Braddish Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 2002 Braddish Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | May 11, 1895 | 54 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Meat | Baltimore, Md. | |

13. FATHER'S NAME: William Patrick Byrne

14. MOTHER'S MAIDEN NAME: Delia A. Ward

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Josephine V. Byrne | 2002 Braddish Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Pancreas | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct 3 '49 | Carcinoma of Head of Pancreas | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1 1949 *to* Dec 7 1949, *that I last saw the deceased alive on* Dec 6 1949, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert Seagmeister M. D. | 1724 W Lombard St | Dec 9 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/10/49 | Cathedral Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Huntington Williams, M.D. | WM. J. TUCKNER & SONS | Balto., Md. |

VS 150

469

80682

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0

Registered No. 80682

1. NAME OF DECEASED (Type or Print): Charles L. Hensler

2. DATE OF DEATH: 12/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 3223 O'Donnell Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | 9/10/1892 | 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Robert Hensler
14. MOTHER'S MAIDEN NAME: Anna Jubb
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Hogan ADDRESS: 3223 O'Donnell St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fatal Embolism — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/1, 1949 *to* 12/9, 1949, *that I last saw the deceased alive on* 12/9, 1949, *and that death occurred at* 7:35 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1213 Light Street
23C. DATE SIGNED: 12/9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/12/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
24D. LOCATION (City, town, or county) (State): B. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949
REGISTRAR'S SIGNATURE: Hunting for Williams, M.D.
25. FUNERAL DIRECTOR: [illegible] & Sons Inc. ADDRESS: 1217 St. Paul St.

VS 150

R. D. FORMAN

124 B

G80683

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80683

1. NAME OF DECEASED (Type or Print): Bertha Kennard

2. DATE OF DEATH: 12-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 337 C Gerta Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 4/1/1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Francis Gerber | Anna Kleinfeld |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Wm L. Kennard | 337 C Gerta Ave Essex |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Sub-acute Lymphatic Leukemia.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| [redacted] m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-9, 19[illegible], *to* 12-9, 1949, *that I last saw the deceased alive on* 12-9-, 1949, *and that death occurred at* 9:37 A.M. *on the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph A. Kumor, M. D. | Univ. Hospital | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | Montclaire Mem. Park | Montclaire Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Huntington Williams, M.D. | [illegible] | [illegible] |

VS 150

74a

G80684
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80684

1. NAME OF DECEASED (Type or Print): HELMUT SCHMIDT

2. DATE OF DEATH: December 2, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hosp.

c. Length of stay in Baltimore: Yrs. ? Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 2-02
D. STREET ADDRESS (If rural, give location): 32 S. Broadway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | ? | ? | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Seaman | | ? | ? |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [✓], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE Earl L Boyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 12-2-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/10/49 | St. Peter's Cemetery | Baltimore Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949

REGISTRAR'S SIGNATURE: Hunter Williams, M.D.

25. FUNERAL DIRECTOR: Earl B Wolcott Funeral Home Inc

ADDRESS: Earl B Wolcott

VS 151

94a

G80685 ✓ Ward No. 1 G80685

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles F. Miller

2. DATE OF DEATH: Dec. 7. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2200 Roslyn Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 64 Years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 2200 Roslyn Ave. B. COUNTY Balto. City

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
Balto MD. 15-48

D STREET ADDRESS (If rural, give location)
2200 Roslyn Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | White | Widowed | Sept 20. 1860 | 89 | 3 | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Atty. at law | Fidelity & Deposit Co. | Westminster Md. | U.S.A. |

13. FATHER'S NAME: George W. Miller

14. MOTHER'S MAIDEN NAME: Charity Brown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Maude miller | 2200 Roslyn Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day Hr.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cardiovascular disease — ?

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 7 , 1949, *to* Dec 7 , 1949, *that I last saw the deceased alive on* Dec 7 , 1949, *and that death occurred at* 9.20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles O. Mitchell M. D. | 2220 Garrison Blvd | Dec 9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Dec. 10. 1949 | Westminster Cemetery | Westminster Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Hunter for Williams, M.D. | John O. Mitchell & Sons | 190 Bltaw Place |

VS 150

John O. Mitchell 931

G80686 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80686 — Registered No.

1. NAME OF DECEASED (Type or Print): Christine E. Brooke
2. DATE OF DEATH: 12/8/49
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md
b. COUNTY: 12-03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24
d. STREET ADDRESS (If rural, give location): 2637 Guilford Ave
e. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2637 Guilford Ave
c. Length of stay in Baltimore: Yrs. Mos. Days
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: Mch 27 1879
9. AGE (In years last birthday): 70 — If Under 1 Year: Months 8, Days 11 — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: home duties
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Horace L. Brooke
14. MOTHER'S MAIDEN NAME: Gay Williams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): no
16. SOCIAL SECURITY NO: [illegible]
17. INFORMANT: Charles E. Brooke
ADDRESS: Guilford Ave 2634

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) — DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: C. E. Schmidt M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED: 12/8/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 10/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): 3501 Frederick ave

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John O. Mitchell & Sons
ADDRESS: 1900 Eutaw Place

VS 151

93D

G80687

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80687

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Jenkins Lee

2. DATE OF DEATH Dec. 9 - 49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-02
D. STREET ADDRESS (If rural, give location) Greenway Apts 3401 Greenway

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenway Apts. Balto

c. Length of stay in Baltimore Life (Yrs. / Mos. / Days)

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: Dec 9 1870
9. AGE (In years last birthday): 79 (Under 1 Year: Months / Days; Under 1 Day: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles O'Donnell Lee
14. MOTHER'S MAIDEN NAME: Matilda Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): Spanish American
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Jos. J. Lee
ADDRESS: Greenway Apts.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs
DUE TO
(B) arteriosclerosis — ?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/27/49, 19__, to 12/9/49, 19__, that I last saw the deceased alive on 12/9/49, 19__, and that death occurred at 1 p m., from the causes and on the date stated above.

23A. SIGNATURE: Francis W Gluck, M. D.
23B. ADDRESS: 3406 St Paul St
23C. DATE SIGNED: 12/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 12 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Henry Jenkins Sons Co
ADDRESS: 49 as York Rd

94a

C80688 ✓ 4-20-✓ C80688

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Blanche R.Albrecht

2. DATE OF DEATH: Dec 9 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2223 W.Lexington St

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-02
D. STREET ADDRESS (If rural, give location): 2223 W.Lexington St

c. Length of stay in Baltimore: 50 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year: Months / Days; If under 24 hours: Hours / Min.) |
|---|---|---|---|---|
| Female | White | Widow | Oct 19 1879 | 70 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Kent Co Md | |

13. FATHER'S NAME: Andrew J.Hopkins

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Catherine L Rosenthal | 2223 W.Lexingt on St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Angina pectoris | 1 year |
| DUE TO | | |
| (B) | Hypertension, | 2 years |
| DUE TO | | |
| (C) | Senility | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 1/10/49 *to* 12/9/49, *that I last saw the deceased alive on* 12/6/49, *and that death occurred at* 2:35 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A Cals M. D. | 47 Fulton Ave | 12/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 13 1949 | Meadowridge | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Emerson Williams, M.D. | Harry H. Simmons | 4204 Ridgewood Ave |

VS 150

94B

680689

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

98 680689

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES F. HENNINGER

2. DATE OF DEATH: 6 December 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland Baltimore, Md.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5200 Belair Road

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 27-01
D. STREET ADDRESS (If rural, give location): 5200 Belair Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Aug. 11th. 1889 | 60 | 3 | 27 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| stone cutter | | Baltimore City, Md. | USA |

13. FATHER'S NAME: Charles F. Henninger

14. MOTHER'S MAIDEN NAME: Carolyn Kahler

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 213-10-3420 | Mrs. C. F. Henninger | 5200 Belair Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Squamous cell carcinoma of carotid gland, primary site undetermined — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1 November 1948 | Squamous cell carcinoma thyroid gland | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Oct. 20 *, 19*47*, to* 6 December *, 19*49*, that I last saw the deceased alive on* 6 December *19*49*, and that death occurred at* 4:10 *a.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John G. Osborne M. D. | 5202 Harford Rd | 9 December 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/12/49 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Curtis Fox Williams, M.D. | Lasanda Funeral Home | 7401 Belair Rd |

VS 150

55E

This alone was pronounced dead 24 hours after J. G. Osborne M.D. embalming

G80690

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80690

1. NAME OF DECEASED (Type or Print): Howard Walter Reinhardt

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto City Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2642 Aisquith St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2642 Asquith St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | white | divorced | June 10, 1885 | 64 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10B. KIND OF BUSINESS OR INDUSTRY: Grocery

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George August Reinhardt

14. MOTHER'S MAIDEN NAME: Mary Ellen Morrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: none

17. INFORMANT: Mrs. Daisey E. Baker — ADDRESS: same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Myocardial Decompensation | 3d. |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis & Hypertension | 14 yrs |
| DUE TO | | |
| (C) | Diabetes Mellitus | 2 yrs |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: No

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 5, 1949, to Dec 7, 1949, *that I last saw the deceased alive on* Dec 7, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: L. J. A. Strauss M. D.

23B. ADDRESS: 2818 Harford Rd

23C. DATE SIGNED: 12-9-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 10/49 | Western | Edmonison Ave. & Longwood St. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25 FUNERAL DIRECTOR: KRAUSE FUNERAL HOME — ADDRESS: 1216 S. Charles

VS 150

61

G80691

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

204.1

Registered No. G80691

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hezekiah McFarland

2. DATE OF DEATH: 12/7/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-02
D. STREET ADDRESS (If rural, give location): 333 Carrollton Ave.

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: 73 Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | W | 1896 | 73 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None (?) | — | Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Clarnon King | Lettie McFarland |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | | Patient & friend (Jake) | 333 Carrollton Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — renal shutdown
DUE TO
(B) Chronic myeloid leukemia
AND DUE TO
(C) Chronic (?) renal disease (study pending)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Malnutrition

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 12/1/ 1949 to 12/7/ 1949, that I last saw the deceased alive on 12/7/ 1949, and that death occurred at 1215 P.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. J. Thenerhouf Jr. M. D. | University Hospital | 12/7/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 12/10/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Thurlington for Williams, M.D. | Chas. H. Herbert | 512 Carrollton Ave |

VS 150

74a

C80692

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3327

C80692 Registered No.

1. NAME OF DECEASED (Type or Print): Harry C. Denton

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 117 N. Front St.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 5-01
D. STREET ADDRESS (If rural, give location): 117 N. Front St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | single | Oct. 15, 1884 | 65 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| not employed | | Gainnville, Fla. | |

13. FATHER'S NAME: Henry Denton

14. MOTHER'S MAIDEN NAME: Catherine McCas

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | World War #1 | | Mrs. R. C. Pearson | Norfolk, Va. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral thrombosis,
DUE TO
(B) with terminal bronchopneumonia.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED: 12/8/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| cremation | 12/10/49 | Greenmount Crem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949

REGISTRAR'S SIGNATURE: Curtis for Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 151

836

C80693

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

161 X C80693 Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | CECELIA HAZLITT |
| 2. DATE OF DEATH | Dec. 8, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 4902 Cordelia Ave. |
| C. Length of stay in Baltimore | 30 yrs. |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore 27-18 |
| D. STREET ADDRESS (If rural, give location) | 4902 Cordelia Ave. |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | March 4, 1896 |
| 9. AGE (In years last birthday) | 53 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Seamstress |
| 10B. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | Carmel, N.J. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Benjamin Corbitt |
| 14. MOTHER'S MAIDEN NAME | Eva Weisfield |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | - |
| 16. SOCIAL SECURITY NO | 218-07-7962 |
| 17. INFORMANT ADDRESS | Mr. James J. Hazlitt - 4902 Cordelia Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Metastatic Carcinoma - origin ? - probably lung ca

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION: Carcinoma | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* June, 1949 *to* Dec 8, 1949 *that I last saw the deceased alive on* Dec 8, 1949 *and that death occurred at* 5.30 P. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| I. Shorofsky M. D. M. D. | 601 N. Howard St. | 12/9/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial | 12/12/49 | Baltimore National Cemetery |
| 24D. LOCATION (City, town, or county) (State) | | |
| Baltimore, Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
| DEC 10 1949 | Hunter for Williams, M.D. | WM. J. TICKNER & SONS Balto., Md. |

VS 150

47a

G80694

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

60

G80694

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CONCETTINA VINCI

2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2655 Francis St.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 2655 Francis St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Dec. 8, 1879 | 70 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank Brocato
14. MOTHER'S MAIDEN NAME: Frances Cagello
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT — ADDRESS: Mrs. Frances Di Leonardi 2655 Francis St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 2 days |
| DUE TO | Arterio-Sclerosis | — |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Diabetes Mellitus | 5 Yrs. |
| DUE TO | | |
| (C) | Obesity | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION: none
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 28, 1949 *to* Dec 8, 1949 *that I last saw the deceased alive on* Dec 8, 1949 *and that death occurred at* 8.40 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Joseph Zucker M. D.
23B. ADDRESS: 2318 Eutaw Place
23C. DATE SIGNED: Dec 9/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/12/49
24C. NAME OF CEMETERY OR CREMATORY: Cathedral Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949
REGISTRAR'S SIGNATURE: Limerick for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: WM. J. TICKNER & SONS Balto., Md.

VS 150

61

G80695

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80695

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Wallace

2. DATE OF DEATH 12/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore Genl Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-47
D. STREET ADDRESS (If rural, give location) 2902 Elgin Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Mar 17, 1860. | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired section Foreman | Railroad | Scotland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| - | - |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. William East | 2902 Elgin Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cardiac arteriosclerotic Cardio vascular Renal disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Benign prostatic hypertrophy | |
| | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/31 *, 19*49*, to* 12/9 *, 19*49*, that I last saw the deceased alive on* 12-9 *, 19*49*, and that death occurred at* 2:10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Bowie Linn Grant M.D. M. D. | W B G H | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Center for Nathanson, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

131a

G80696

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80696

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARGARET VIRGINIA VOLK

2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3604 Mohawk Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-01
D. STREET ADDRESS (If rural, give location): 1 Stratford Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | May 9, 1863 | 86 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| unknown | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Francis Volk | Eliza Rhine |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| - | - | Mr. P. Irvin Volk | 1 Stratford Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic Heart Disease | 3 years |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 1, 1949 *to* Dec 9, 1949, *that I last saw the deceased alive on* Dec 9, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard H. Warner M. D. | 2604 Garrison Blvd | 12-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Baltimore Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

- 8 -

93D

G80697

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80697

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GERTRUDE R. FENSTERWALD

2. DATE OF DEATH Dec. 8th, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Georgian Court Aprt.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 64yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
STATE Balto. Md.
B. [illegible] residence
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-01
D. STREET ADDRESS (If rural, give location) Georgian Court Apts.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | October 5 1880 | 69 | 1 23 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Germany | U.S. |

13. FATHER'S NAME Selgiman Rothchild

14. MOTHER'S MAIDEN NAME Hannah Burk

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Mr. Henry Fensterwald | Georgian Court Apt |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute uremia | 3 days |
| DUE TO (B) | Cardio-renal-vascular disease | 5 yrs |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Diabetes - hypertension arteriosclerosis | 5 yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| ✓ | ✓ | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | ✓ | ✓ |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| ✓ m. | | ✓ |

22. I hereby certify that I attended the deceased from Sept 1949, to Dec 8, 1949 that I last saw the deceased alive on Dec. 8, 1949, and that death occurred at 9.52 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Frederick Lentz M. D. | Temple Gardens | Dec 9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 11, 1949 | Hebrew Friendship | Phila Rd Balto, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Thurlington Williams, M.D. | David Sondheim & Son 1902 | Eutaw Place |

VS 15a

Dr. was last 3 yrs. Pt. had attended patient Gerald frequently for various attacks.

David Sondheim & Son

61

C80698

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80698

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Ursula Prestrail

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Hosp. 2 - wd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE; B. COUNTY: Trinidad, West Indies

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Port of Spain 7-5

D. STREET ADDRESS (If rural, give location): 12 Sweet Briar Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 11-16-189- | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | West Indies | |

13. FATHER'S NAME: Francis Losada

14. MOTHER'S MAIDEN NAME: Christina Mendosa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: Johns Hopkins Hospital

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral anoxia | app. 1 hr. |
| DUE TO (B) | Postoperative pulmonary collapse | app. 3 days |
| DUE TO (C) | Lymphosarcoma of stomach | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12/2/49 | LYMPHOSARCOMA OF STOMACH | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-2-, 1949 *to* 12-10-, 1949, *that I last saw the deceased alive on* 12-10-, 1949, *and that death occurred at* 5 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Nelson M.D. | [illegible] | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Dec 10/49 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| DEC 10 1949 | Huntington Williams, M.D. | Wm. L. Sinnott Son 2008 Eutaw |

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46B

80699

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80699

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CLARIBEL SKINNER

2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1100 Steelton Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 65 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-06
D. STREET ADDRESS (If rural, give location): 1100 Steelton Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 23, 1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Salisbury, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Trader | — |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Vernon Skinner | 2902 Dunbrin Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Cardio vascular renal disease. — DUE TO

(B) renal disease. — DUE TO

(C) Hypertension.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: over 6 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H McLearnon M.D. M. D. | 88 Balto. Ave. Dundalk | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | Greenmount Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Registrar for Williams, M.D. | Ullrich Funeral Home | 2008 Orleans St. |

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G80700

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80700

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Adolph Roessler

2. DATE OF DEATH: Dec. 6th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 415 Yale Ave
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-C
D. STREET ADDRESS (If rural, give location): 415 Yale Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 12-18-1880 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md. | USA. |

13. FATHER'S NAME: Ernest Roessler

14. MOTHER'S MAIDEN NAME: Marie Braunroeder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 216-18-0902

17. INFORMANT: Henry E. Roessler — ADDRESS: 2531 Hollins St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Myocardial insufficiency 3 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Summer 1947 *to* Dec. 6th 1949 *that I last saw the deceased alive on* Dec 6 1949 *and that death occurred at* 7:20 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. Williamson | 3325 Frederick Rd | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 10/49 | New Cathedral | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949

REGISTRAR'S SIGNATURE: Contingent Williams M.D.

25. FUNERAL DIRECTOR: J. B. Wippert & Son — ADDRESS: 1300 Eutaw Pl.

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✓ X G80701

G80701

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

57-1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stirling Grigg

2. DATE OF DEATH: Dec 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Mercy - ward

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richmond 22
D. STREET ADDRESS (If rural, give location): 1008 Hanquier Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1-7-77 | 50 | 11 | 8 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tobacconist | | a. | |

13. FATHER'S NAME: Francis Grigg

14. MOTHER'S MAIDEN NAME: Rebecca Tucker ✓

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: Johns Hopkins Hospital

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 6 days |
| DUE TO (B) | Diarrhea of unknown etiology | 12 mos. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-18-, 1949 *to* 12-12-, 1949 *that I last saw the deceased alive on* 12-12-, 1949 *and that death occurred at* 7 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. C. Sandell Jr. M.D. | JOHNS HOPKINS HOSPITAL | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | Forest Lawn | Richmond, Richmond Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Huntington Williams M.D. | Wm. J. Tuckner & Son | Balto Md. |

VS 150

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120a

G80702

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3/31

G80702 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Dolores Randall

2. DATE OF DEATH: 12-8-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2014 Clifton Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2014 Clifton Ave 15-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | Feb. 12, 1926 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto. Md. | U.S.A. |

13. FATHER'S NAME: William Winder

14. MOTHER'S MAIDEN NAME: Clara ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Dennis Randall | 2014 Clifton ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949, to Dec 8, 1949 *that I last saw the deceased alive on* Dec 8, 1949, *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Julius B. White M.D. | 1802 Penna. Ave. | 12/10/1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 12-11-1949 | W.F. Auburn Cem. | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | UNDERTAKER OR FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | [illegible] for Williams | Wm Hakie R. Williams & Schroeder | 39 |

VS 150

83a

G80703

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80703
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dora May Hardy

2. DATE OF DEATH Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1912 W. Pratt St.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-03
D. STREET ADDRESS (If rural, give location) 1912 W. Pratt St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Mar. 21, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Maryland | U.S.A. |

13. FATHER'S NAME John Koss

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | None | None | Alfred Hardy | 1912 W. Pratt St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Rectum + Pelvic organs — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Hemorrhage Rectum

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 28, 1949 *to* Dec 8, 1949 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1:10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hugo Roedenbeck M.D. M.D. | 1915 W. Pratt St. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Thomas J. Williams | Geo. L. Schwab | 2101 Frederick Ave. |

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G80703

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C 16 G80704 Registered No.

1. NAME OF DECEASED (Type or Print): NUMER WILLIAM

2. DATE OF DEATH: Dec 10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Sinai Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 10 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Pennsylvania
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homestead
D STREET ADDRESS (If rural, give location) 3305 Dorithea Rd #15

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | | 47 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Adjuster

10B. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Penn

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David

14. MOTHER'S MAIDEN NAME: Rachael

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Morton Caplan ADDRESS 868 Park Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Kidney insufficiency & Uremia
DUE TO
(B) Genito urinary tuberculosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/4, 1949, to Dec 10, 1949, *that I last saw the deceased alive on* Dec 10, 1949, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23A. SIGNATURE M. Todbergen M.D. M. D.

23B. ADDRESS Sinai Hospital

23C. DATE SIGNED 12/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 17-10-49

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county) (State) Pittsburgh Pa

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949

REGISTRAR'S SIGNATURE: Hunter Sr Williams M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS 2100 Eutaw Pl

20

C80705 C80705

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

170 Registered No.

1. NAME OF DECEASED (Type or Print): Fannie Ruth Caplan

2. DATE OF DEATH: December 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3709 Springdale Ave
c. Length of stay in Baltimore: 26 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-38
D. STREET ADDRESS (If rural, give location): 3709 Springdale Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | May 25, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Eli Gordon

14. MOTHER'S MAIDEN NAME: Mary ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Maurice M Caplan | 3709 Springdale Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized Carcinomatosis | 6 months |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Carcinoma Right breast | 7/48 |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 7/48 | Carcinoma Rt. breast | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9/21, 1948 *to* 12/10, 1949, *that I last saw the deceased alive on* 12/10, 1949, *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4320 Eldon Rd | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 11, 1949 | Hebrew Washington Rd Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | [signature] | Sol Levinson & Bros | 1126 W North Ave |

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G80706

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

493 Registered No. G80706

1. NAME OF DECEASED (Type or Print): Esther Jacobs
2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2211 E. Lombard St.
c. Length of stay in Baltimore: 42 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-05
D. STREET ADDRESS (If rural, give location): 2211 E. Lombard Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 1861 | 88 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.a.

13. FATHER'S NAME: Henry Weinblatt
14. MOTHER'S MAIDEN NAME: Rose ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Philip Jacobs - ADDRESS: 2204 E. Baltimore St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia (Hypostatic) — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

DUE TO

(B) Invalidism - [illegible] — 5 yrs.

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 7, 1949 to Dec. 9, 1949, that I last saw the deceased alive on Dec. 8, 1949 and that death occurred at 4 P. m., from the causes and on the date stated above.

23A. SIGNATURE: Harry Linden, M. D.
23B. ADDRESS: 14 S. Broadway
23C. DATE SIGNED: Dec. 10, '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-11-49
24C. NAME OF CEMETERY OR CREMATORY: Adas Israel - Beth Isaac
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 10 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson & Bro.
ADDRESS: 1124-26 W. North Avenue

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G80707

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80707

BIRTH NO. G80707 49-28360

1. NAME OF DECEASED (Type or Print): Baby Boy Wieland

2. DATE OF DEATH: 12-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-04
D. STREET ADDRESS (If rural, give location): 2221 No Pulaski St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | W | S | 12-9-49 | | | 22 9 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Newborn | | Md. | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Wieland | Evelyn Myerberg |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Henry Wieland 2221 N Pulaski St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) atelectasis

DUE TO

(B) mucous Plug ??

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-9-, 1949, to 12-10, 1949, *that I last saw the deceased alive on* 12-10-, 1949, *and that death occurred at* 9 55 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Univ. Hosp. | 12-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-11-49 | Baltimore Hebrew | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

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G80708

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 174 G80708 Registered No.

1. NAME OF DECEASED (Type or Print): MARY RANKIN
2. DATE OF DEATH: 12-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3302 West Garrison Ave
C. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 3302 W. Garrison Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

13. FATHER'S NAME: Solomon
14. MOTHER'S MAIDEN NAME: Fluma

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Minnie Barve | 3111 Leighton Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno carcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Generalized Carcinomatosis
DUE TO
(C) Cardio Respiratory Failure

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1942 | Adeno carcinoma of uterus | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12/8/49 19__, to 12/10/49, that I last saw the deceased alive on 12/10/49, and that death occurred at 3:20 p. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Willard Applefeld M. D. | 2511 Reisterstown Rd | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-11-49 | Woodlawn Mem Pk | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Huntington Williams, M.D. | Jack Levin Inc | 2100 Eutaw Place |

VD 150

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G80709

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80709

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Daniel Weintraub

2. DATE OF DEATH: 12/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1815 East Fairmount Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | M | | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| General | Mens Hats | Russia | |

13. FATHER'S NAME: Asher

14. MOTHER'S MAIDEN NAME: Odell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Anna Weintraub 1815 E Fairmount |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(B) Coronary Thrombosis with Myocardial Infarction — 8 days
DUE TO
(C) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/4, 1949 *to* 12/9, 1949 *that I last saw the deceased alive on* 12/9, 1949 *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leon E Kassel M. D. | Sinai Hospital | 12/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12-11-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Lemuel Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

93D

G80710 ✓ G80710

BIRTH NO. 49-26698

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Jacobson

2. DATE OF DEATH: December 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for the Women of Md.
c. Length of stay in Baltimore: 1 1/2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-13
D. STREET ADDRESS (If rural, give location): 45-24 Reisterstown Road.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | 12-7-49 | | | 1 | 10 | 50 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Maryland | U.S.A. |

13. FATHER'S NAME: Abe Clifford Jacobson
14. MOTHER'S MAIDEN NAME: Jessie Katzenetz
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: none
17. INFORMANT: Jessie Jacobson ADDRESS: 45-24 Reisterstown Rd. Baltimore

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(B) Atalectasis, Enlat
DUE TO
(C) Prematurity, extreme

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Dec 7, 1949 to Dec. 9, 1949 that I last saw the deceased alive on Dec. 9, 1949, and that death occurred at 6:38 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Spencer, Jr. M.D. | Hosp. for Women of Md. | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-11-49 | Rosedale | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Beatrice Von Williams, M.D. | Jack Levin Inc. | 2100 Eutaw Place |

VS 1150

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G80711

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80711

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Lilian L. Strother

2. DATE OF DEATH Dec 8th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 637 St. Annes Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 9-07
D. STREET ADDRESS (If rural, give location) 637 St. Annes Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Jan 30th 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sewing | | Md | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm Grosbans | Sophia Gaeuber |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr Robt Grosbans | 4503 Kenwood Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive arteriosclerotic heart Disease

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 29, 1949, *to* Dec. 8, 1949, *that I last saw the deceased alive on* Dec. 1, 1949, *and that death occurred at* 7:20 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Adam G Suess M. D. | 6232 Belair Rd. | Dec. 9, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 12th 1949 | Parkwood | Taylor Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 10 1949 | Thomas for Williams, M.D. | Leo F. Leach | 1703 N. Patterson Park Ave |

VS 150

Dr Suess 6232 Belair Road

937

G80712

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G80712

1. NAME OF DECEASED (Type or Print): Margaret A Monath

2. DATE OF DEATH: Dec 9, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 6028 Old Harford Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Beech Hill Nursing Home

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 2617 Kirk Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | April 12 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | ** | Baltimore Md | U.S. |

13. FATHER'S NAME: John N Hanson

14. MOTHER'S MAIDEN NAME: Elizabeth Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT / ADDRESS: Mrs W Neumann 2617 Kirk Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* October, 1949 *to* December, 1949 *that I last saw the deceased alive on* December 2, 1949, *and that death occurred at* 10:10 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Raymond E. Watson M. D. | 1300 N. Calvert St. | 12-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 12 1949 | Mt Carmel | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 10 1949 | [illegible] | J Melville Jenkins 2713 Kirk Ave |

VS 15B

52 B

G80713

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9 83 G80713 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Dubell — N-803.2

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

c. Length of stay in Baltimore: 15 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Pikesville
D STREET ADDRESS (If rural, give location): 7207 Rockridge Rd.

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | May 5 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Insurance Agent | Insurance | Baltimore. Md | |

13. FATHER'S NAME: James C. Dubel

14. MOTHER'S MAIDEN NAME: Susie A Minnick

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes World War I | 215 01 3592 | Mrs Ada A Dubel | 7207 Rockridge Rd |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull c

DUE TO

(B) Intracranial Hemorrhage

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Yard of 433 W. Hamburg St.

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found lying in yard, rear of 433 W. Hamburg St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 2, 1949 6:30 p. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Blunt force (hit on head with piece of wood)

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Earl L Rye M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: Dec. 10, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | Druker | Pikesville Md Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: T A Hardesty & Son Pikesville ADDRESS: 168 V. Md

VS 151

Med. Exams. Case CERTIFICATE CORRECTED 12-20-49

Released 12-19-49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17 C80714 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cora Grimm

2. DATE OF DEATH: Dec 10 '49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md -
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-24
D. STREET ADDRESS (If rural, give location): 1229 63rd St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 9-25-82 1885 | 64 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Ohio - | |

13. FATHER'S NAME: Solomon Combs

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Records. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Breast with
DUE TO Generalized Metastases and
(B) Pathologic fractures of ribs
DUE TO vertebrae and right femur
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH: 1936 - 1949

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| None | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | 1229 - 63rd St |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov 3 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fall at home |

22. I hereby certify that I attended the deceased from Nov. 3 1949 to Dec 10, 1949 that I last saw the deceased alive on Dec 10, 1949 and that death occurred at 9:50 a m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert S Wilson M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/12/49 | | Zanesville Ohio |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1 1949 | Livingston Williams, M.D. | Mildred J. Blight | 6009 Harford Rd |

VS 1501

To be approv. by Med Exams

Earl L Rogers, M.D. 50

C80715 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 19 C80715 Registered No.

1. NAME OF DECEASED (Type or Print): George Martin Mathias

2. DATE OF DEATH: December 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2910 Manhattan Avenue
c. Length of stay in Baltimore: 37 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-14
D. STREET ADDRESS (If rural, give location): 2910 Manhattan Avenue

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 19, 1874
9. AGE (In years last birthday): 75 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Station Agent
10B. KIND OF BUSINESS OR INDUSTRY: Pa. R. R. Retired 5 years

11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Mathias
14. MOTHER'S MAIDEN NAME: Catherine Duhling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ---
17. INFORMANT: Robert B. Mathias ADDRESS: 214 Goodale Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of penis
DUE TO
(B)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) Arteriosclerotic C.V. disease

INTERVAL BETWEEN ONSET AND DEATH: 5 months

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 9, 1949, *to* 12 9, 1949, *that I last saw the deceased alive on* 12 9, 1949, *and that death occurred at* 1:20 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul E. Carlevier M. D.
23B. ADDRESS: 2217 South Rd
23C. DATE SIGNED: 12/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 12, 1949
24C. NAME OF CEMETERY OR CREMATORY: Union Cemetery
24D. LOCATION (City, town, or county) (State): Manchester, Pennsylvania

DATE RECEIVED BY LOCAL REGISTRAR: 12 11 1949
REGISTRAR'S SIGNATURE: Lucretia Williams M.D.
25. FUNERAL DIRECTOR ADDRESS: Burgee Funeral Home 3631 Falls Road

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G80716

BIRTH NO. 49-27068

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80716
Registered No.

1. NAME OF DECEASED (Type or Print): Baby McNew

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 2101
D. STREET ADDRESS (If rural, give location): 1937 Eastern Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 12-10-49 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: William McNew

14. MOTHER'S MAIDEN NAME: Dolores Superzinski

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Wm. McNew | 1982 Eastern Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO prematurity
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hydrocephalus mother has Lues

INTERVAL BETWEEN ONSET AND DEATH: —

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-10-49, 19__, to __, 19__, *that I last saw the deceased alive on* 12-10, 1949 *and that death occurred at* 9:40 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph S. Ardinger M. D. | St. Agnes Hospital | 12-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 12/49 | St Stanislaus | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 11 1949 | Lucretia Williams, M.D. | Fred W Ozazewski | 1980 Eastern Ave |

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G80717

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80717
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. FERGUSON

2. DATE OF DEATH 12/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

C. Length of stay in Baltimore 44 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1800 WILMINGTON AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | MAR 4, 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | UNK. | BALTIMORE | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Mr Wm H. FERGUSON | HATTIE A. SNYDER |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| UNK | NONE | NONE | WIFE | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia

DUE TO

ANTECEDENT CAUSES

(B) Chronic tuberculous pyelonephritis

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Pulmonary Tuberculosis.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/6, 1949, *to* 12/11, 1949, *that I last saw the deceased alive on* 12/11, 1949, *and that death occurred at* 12:10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A. Ranson M. D. | Union Memorial Hospital | Dec. 11, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-14-49 | Loudon PARK | BALTIMORE Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Huntington Williamsville | Geo. L. Schwab | 2101 FREDERICK AVE. |

13B

G80718 ✓ 20. 1 G80718

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Vaclav James Gasoch
2. DATE OF DEATH: Dec. 8/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Johns Hopkins
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-03; D. STREET ADDRESS (If rural, give location) 916 N. Collington Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): John Hopkins 61 Yrs. Mos. Days
c. Length of stay in Baltimore

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M. | W. | Widowed | Nov 16 1888 | 61 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ceston Gasoch
14. MOTHER'S MAIDEN NAME: Barbara Krumel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: James Gasoch ADDRESS 916 N Collington Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Occlusion | Dec. 7 49 |
| DUE TO (B) | Chr. Myocarditis | 5-1-49 |
| DUE TO (C) | Chr Parenchymatous Nephritis | 5-1 49 |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1 49 *to* Dec 8 49, *that I last saw the deceased alive on* Dec 8 49 *and that death occurred at* 1 2 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Grauer M. D. | 8014 Kenwood Ave | 12/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | Holy Redeemer | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS Frank Gasoch & Son 900 Lehmter

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DEC 11 1949

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G80719

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 17

Registered No. G80719

1. NAME OF DECEASED (Type or Print): Grace Toffey Tilden

2. DATE OF DEATH: Dec-10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland N. Charles St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Warrington Apts. 3908 N. Charles Street

c. Length of stay in Baltimore: Yrs. 35 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City 12-01
D. STREET ADDRESS (If rural, give location): Warrington Apts., (3908 N. Charles St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March-5-1874
9. AGE (In years last birthday) / If Under 1 Year: Months / Days / If Under 24 Hours: Hours / Min.: 75 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): - - . - -
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William V. Toffey
14. MOTHER'S MAIDEN NAME: Emma Louise Sip
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT / ADDRESS: Mr. Marmaduke Tilden (husband) Balto. Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of body of uterus — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION: Jan. 17, '49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of body of uterus which had infiltrated into pelvic wall.
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 24, 1939, *to* Dec. 10, 1949, *that I last saw the deceased alive on* Dec. 9, 1949, *and that death occurred at* 1:00 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John Tilden Howard M. D.
23B. ADDRESS: 12 E. Eager St., Balto
23C. DATE SIGNED: Dec. 10, '49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 12 49
24C. NAME OF CEMETERY OR CREMATORY: Pawling Cemetery
24D. LOCATION (City, town, or county) (State): Pawling, New York.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: [illegible], M.D.
25. FUNERAL DIRECTOR / ADDRESS: Stewart & Mowen Company, 103 W. North Ave.

48B City #1.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): (Miss) Annie Strohl

2. DATE OF DEATH: Dec-9-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2803 Garrison

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Samson Nursing Home

C. Length of stay in Baltimore: 4 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE D. C. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Washington D.C.

D. STREET ADDRESS (If rural, give location)

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: abt-1869

9. AGE (In years last birthday): abt 80

If Under 1 Year: Months / Days

If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious

10B. KIND OF BUSINESS OR INDUSTRY: Salvation Army

11. BIRTHPLACE (State or foreign country): Allentown Pa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Could not Ascertain

14. MOTHER'S MAIDEN NAME: Could not Ascertain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Salvation Army ADDRESS: 336 St Paul

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chr. Valvular Heart

DUE TO

(B) Chronic Interstitial Nephritis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

(A) 1945

(B) 1945

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* June 19, 1949 *to* Dec 9, 1949 *that I last saw the deceased alive on* Dec 9, 1949 *and that death occurred at* 2 3/4 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Paul Ruan M. D.

23B. ADDRESS: 1163 W 41st St.

23C. DATE SIGNED: 12-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec-13/49

24C. NAME OF CEMETERY OR CREMATORY: Westview

24D. LOCATION (City, town, or county) (State): Atlanta Ga.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: Stewart Mortuary ADDRESS: Balto.

VS 150

DEC 17 1949

Funeral for Williamsburg, Md.

131a

G80721

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80721

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MORRIS KING SPENCER

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 702 Cator Ave.,
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 9-01
D. STREET ADDRESS (If rural, give location): 702 Cator Ave.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 1, 1911 | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Draftsman | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James U. Spencer | Panola VanBuskirk |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | W.W. 2 | | Mrs. Margaret C. Spencer | 702 Cator Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary occlusion, recurrent | 10 mos |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Coronary arteriosclerosis | 7 |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arterial hypertension | 4 yrs |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Oct 1947 *to* Dec 1949, *that I last saw the deceased alive on* Dec 1, 1949, *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frederick J. Vollmer M. D. | 6100 York Road | Dec 8 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Woodlawn | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 11 1949 | Lurlington Williams, M.D. | G. Howard Strong | 3207 W. North Ave., |

VS 150

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G80722

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80722

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH SCHWARTZ

2. DATE OF DEATH: 12/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6-14

c. Length of stay in Baltimore: 37 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1811 East Fairmount Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital records ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
A) Pulmonary edema
DUE TO
B) ASHD
DUE TO
C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ~~Perforated~~ Penetrating Pyloric ulcer

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/10 *to* 12/10, 1949 *that I last saw the deceased alive on* 12/10, 1949 *and that death occurred at* 10 A.M. *from the causes and on the date stated above.*

23A. SIGNATURE: William Rabinowitz M.D.

23B. ADDRESS: Sinai Hospital

23C. DATE SIGNED: 12/11/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-11-49

24C. NAME OF CEMETERY OR CREMATORY: Rosedale

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 11 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eastern Ave

VS 150

117a

C80723 ✓ C80723

BIRTH NO. 49-09032

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

49 Registered No.

1. NAME OF DECEASED (Type or Print): Donald Brady

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Belto City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-33
D. STREET ADDRESS (If rural, give location): 2310 Annapolis Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| M | c | Baby | 5/6/1949 | | 7 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baby | | Baltimore Maryland | U.S.A. |

13. FATHER'S NAME: Lemmie Brady

14. MOTHER'S MAIDEN NAME: Coraldine Beads

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Geralaine Brady | 2310 Annapolis Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Interstitial Pneumonitis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil Rupp M.D. | | Dec. 9, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/1949 | Arburn Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Washington Williams, M.D. | Elroy C. Wilson | 1000 Brantly Ave. |

VS 151

114E

BIRTH NO. G80724

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80724

1. NAME OF DECEASED (Type or Print): Samuel L. Allen
2. DATE OF DEATH: Dec. 6, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
C. Length of stay in Baltimore: 12 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05
D. STREET ADDRESS (If rural, give location): 823 McDonough St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Divorced | 11/1/1903 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Preeser | Cleaning Shop | North Carolinia | U.S.A. |

13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Mary ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mary Boler | 823 McDonough Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Myocardial insufficiency | |
| | DUE TO luetic aortitis with coronary ostial stenosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Encephalomalacia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [X] / ASSISTANT MEDICAL EXAMINER [ ] / MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Dec. 6, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/1949 | Mt Calvery Cem. | Brooklyn A.A.Co.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12-11-49 | Huntington Williams, M.D. | Elroy C. Wilson | 1000 Brantly Ave |

VS 151

30D

C80725 C80725

BIRTH NO. C80725

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): PATRICK M. SCALLY
2. DATE OF DEATH: 12-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSP
C. Length of stay in Baltimore: 30 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto
B. COUNTY: Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 9-07
D. STREET ADDRESS (If rural, give location): 2528 Aisquith St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | SINGLE | Mar 1, 1877 | 72 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartendar
10B. KIND OF BUSINESS OR INDUSTRY: Tavern
11. BIRTHPLACE (State or foreign country): Cockeysville, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Patrick Scally
14. MOTHER'S MAIDEN NAME: Anna Cummings.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 216-20-8418
17. INFORMANT: Miss Thereas Scally ADDRESS: 2528 Aisquith S

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive cardiovas disease | 10 years |
| DUE TO | | |
| (C) | 4th degree cardiac failure | 3 wk. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-4, 1949 *to* 12-9, 1949, *that I last saw the deceased alive on* 12-9, 1949 *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Burton U Lock MD M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 12-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-112-49
24C. NAME OF CEMETERY OR CREMATORY: St. Josephs Texas
24D. LOCATION (City, town, or county) (State): Balto., Co.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 1 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: WIEDEFELD & SON
ADDRESS: GREENMOUNT AVE & 22ND
931

G80726

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G80726 Registered No. 4

1. NAME OF DECEASED (Type or Print): MOLLIE V. MAURER

2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 236 N. Payson St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-01
D. STREET ADDRESS (If rural, give location): 236 N. Payson St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Nov. 20, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Maryland | |

13. FATHER'S NAME: Henry Ellis

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Mrs Chlydia Brunnen, ADDRESS: 236 N. Payson St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIAC DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CARDIAC WEAKNESS — INTERVAL BETWEEN ONSET AND DEATH: several yrs

DUE TO

(C) SENILITY

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan, 1949 *to* DEC 9, 1949, *that I last saw the deceased alive on* DEC 9, 1949, *and that death occurred at* 7: P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Ellsworth Cook M.D. | 2431 MARYLAND AVENUE | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 11 1949 | Registrar for Williamsburg, Md. | William Cook, Inc., 1217 St. Paul St. |

95c

G80727 ✓ 44 G80727 27

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Georgia Martin

2. DATE OF DEATH: Dec 8 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 Conca St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 803 Conca St 26-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Oct 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown Isrell | Wynne |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Mary Shultz | 803 Conca St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchial - Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis Hypertension

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/5, 1949 *to* 12/8, 1949 *that I last saw the deceased alive on* 12/5, 1949 *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. B. Reese M. D. | 3400 Edmondson Ave | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | Glen Haven | Glen Burnie Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 11 1949 | Beatrice Williams, M.D. | W. M. Cook Inc | 1217 E. Pratt St |

VS 150

107

G80728

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54 G80728 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JUSTICE, OSCAR SAMUEL

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S. MARINE HOSPITAL, BALTIMORE

C. Length of stay in Baltimore: 3 Yrs. 6 Mos. 9 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: Somerset
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CRISFIELD
D. STREET ADDRESS (If rural, give location): —

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | JUN 18, 1889 | 60 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| G&S + Elec. Co. | — | Virginia | USA. |

13. FATHER'S NAME: Alfred Justice

14. MOTHER'S MAIDEN NAME: Minnie Killmon

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| UNKNOWN | — | A B Morrow, M.D. | USMH. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hemorrhage | Unknown. |
| DUE TO | Gastric ulcer | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Adenocarcinoma of rectum with generalized metastases | About 2 yrs. |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10-28-48 | Ca rectum & metastases | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Oct. 3 1949, *to* Dec. 11, 1949, *that I last saw the deceased alive on* Dec. 10, 1949, *and that death occurred at* 5:45 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Andrew B. Morrow M. D. | U.S. Marine Hosp. | Dec 11, 1949. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12-11-49 | | Crisfield Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 11 1949 | [illegible] | Mildred T Blight | 609 Hanford Rd. |

VS 150

467

C80729 ✓ 153 C80729

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): George M. Hardesty

2. DATE OF DEATH: Dec. 10 - 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2218 McElderry St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2218 McElderry St. 7-3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | July 16 - 1915 | 34 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Brakeman | Penn. R. R. | Balto. Md. | |

13. FATHER'S NAME: J. W. Hardesty

14. MOTHER'S MAIDEN NAME: Eliza. Holleby

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | J. W. Hardesty | 2218 McElderry St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Large Intestine ?
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* 10 Dec, 1949 *that I last saw the deceased alive on* 9 Dec, 1949 *and that death occurred at* 12.30 A m., *from the causes and on the date stated above.*

| 22A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Silverfield M. D. | 714 E. Preston St. | 10 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 14-49 | Carpenters Com. | Brentwood Co. Jackson Kentucky |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 11 1949 | Huntington Williams, M.D. | John B. Miller | 2334 Jefferson St. |

VS 150

46E

G80730

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80730

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Watson

2. DATE OF DEATH: Dec. 11th 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1218 St. Matthews St.

C. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1218 St. Matthews St. S-01

5. SEX: Male
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 1892
9. AGE (In years last birthday): 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Unable to Work
11. BIRTHPLACE (State or foreign country): Accomac Co. Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edward Watson
14. MOTHER'S MAIDEN NAME: Mary Watson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ebbie Annis ADDRESS: 1218 St. Matthew St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earle H. Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 12-16-49
24C. NAME OF CEMETERY OR CREMATORY: Star of East
24D. LOCATION (City, town, or county) (State): Accomac, Virginia

DATE RECEIVED BY LOCAL REGISTRAR: DEC 11 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: J. Edgar Thomas
ADDRESS: Accomac

VS 151

93D

G80731 BALTIMORE CITY HEALTH DEPARTMENT G80731

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Anna T. Robison
2. DATE OF DEATH: 12-8-1949
3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 437 E. Gittings St.
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 437 E. Gittings St. 24-02
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 20. 1871
9. AGE (In years last birthday): 78 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Michael Powell
14. MOTHER'S MAIDEN NAME: Louise Rowleather
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Isaac Robison ADDRESS: 437 E. Gittings St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Sclerosis

DUE TO

(B) Arteriosclerosis, Hypertension

DUE TO

(C) Myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov 10 49 *to* Dec 8 49, *that I last saw the deceased alive on* Dec 8 49, *and that death occurred at* 930 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John A. Behrmann M. D.
23B. ADDRESS: 1337 S. Charles St.
23C. DATE SIGNED: 12/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 11 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: Flynn & Fleming ADDRESS: 1426 Light St.

VS 150

937

G80732

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

18 Registered No. G80732

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Louise B. Crossy

2. DATE OF DEATH: 12/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Mercy Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Windsor, Md
D. STREET ADDRESS (If rural, give location): Route #2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 12/13/1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | U. S. A. |

13. FATHER'S NAME: Samuel Brewer

14. MOTHER'S MAIDEN NAME: Laura Weossner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Daughter | Tucson, Arizona |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Bladder — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/7/49, 19__, *to* 12/10/49, 19__, *that I last saw the deceased alive on* 12/10/49 19__, *and that death occurred at* 05 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard F. Raskin M. D. | Mercy Hospital | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | London Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Fulton Corp. | 1217 St Paul St |

VS 150

520

G80733

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

776 G80733

Registered No.

BIRTH NO. 49-26539

1. NAME OF DECEASED (Type or Print): Baby Smith

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp.

C. Length of stay in Baltimore: Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3411 Ash St. 13-8

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Dec. 6, 1949 | | | 5 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| infant | | Maryland | |

13. FATHER'S NAME: Howard E. Smith.

14. MOTHER'S MAIDEN NAME: Margaret Harding

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Howard E. Smith | 3411 Ash St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | 5 days |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 6, 1949 *to* Dec. 11, 1949 *that I last saw the deceased alive on* Dec. 11, 1949, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. Donald Emery M. D. | Union Memorial Hosp. | Dec. 12, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-14-49 | Old Oakland | Mt. Lookeville, Carroll Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | C. F. Weer - Lykesville, Md. | |

VS 150

159

Correct age is especially important. Explanation: please write the causes of death clearly and legibly.

G80734

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E976-0 G80734

Registered No.

1. NAME OF DECEASED (Type or Print): Walter Bennett — N-853.4

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1636 Jackson St. 24-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | April 20, 1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.A. Pensioner

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Bennett

14. MOTHER'S MAIDEN NAME: Amy ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO: 213-01-9485

17. INFORMANT: Mrs. Mary Bennett — ADDRESS: 1636 Jackson St.

## MEDICAL CERTIFICATION

## CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bullet wound of brain — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1636 Jackson St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 8, 1949 5P m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Kaye M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Dec. 9, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 12, 1949 | Baltimore Cemetery | Baltimore — Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: A. Howard Evans — ADDRESS: 1400 S. Charles St.

VS 151

164 c

Correct age is especially important. If unknown, please write the reason on death certificate and legibly.

G80735

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80735

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK PATTERSON

2. DATE OF DEATH 12/8/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 29 N. Eden Street

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 29 N. Eden Street 5-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | married | 9-14-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Porter | Sun Balto. Press | Baltimore Md. | |

13. FATHER'S NAME Daniel Patterson

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes World War #1 | 218-03-8720 | Leonie Patterson | 29 N. Eden St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Collapse — Interval between onset and death: 1 hr

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Occluded Failure — 6 m

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/1, 1949, *to* 12/5, 1949, *that I last saw the deceased alive on* 12/6, 1949, *and that death occurred at* 6 11 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Dellmann M. D. | 1442 N. Calvert | 12/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-1949 | Balto. National | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Randolph J. Collick | 1532 Biddle St. |

VS 150

95c

G80736

BIRTH NO. 49-26 491

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80736

1. NAME OF DECEASED (Type or Print) [redacted] EDWARD G. Gegner JR.

2. DATE OF DEATH Dec. 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D. STREET ADDRESS (If rural, give location) 2038 Robb St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | | Dec. 5, 1949 | | 5 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward Gegner
14. MOTHER'S MAIDEN NAME MARY ANN PENNINGTON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS EDWARD GEGNER SR. 2038 ROBB ST.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tetany ?
DUE TO
(B) low Calcium
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Prematurity

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5 1949 *to* 12-10 1949, *that I last saw the deceased alive on* 12-10 1949, *and that death occurred at* 9:15 A m., *from the causes and on the date stated above.*

23A. SIGNATURE Joseph S. Gedenger M. D.
23B. ADDRESS St. Agnes Hosp
23C. DATE SIGNED 12-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-13-49
24C. NAME OF CEMETERY OR CREMATORY London Park Cem.
24D. LOCATION (City, town, or county) Frederick Ave. Balto Md (State)

DATE RECEIVED BY LOCAL REGISTRAR DEC 12 1949
REGISTRAR'S SIGNATURE Curtis Williams M.D.
25. FUNERAL DIRECTOR John C. Milly Inc.
ADDRESS 2435 E. Oliver St

VS 150

159

Correct age is especially important. If incorrect, please write the correct date of death clearly and legibly.

G80737

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80737 Registered No. 1388-49

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. CLARA I. WRIGHT

2. DATE OF DEATH: 12-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. Agnes Hospital
c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 719. E. 34th. st.

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | widowed | 7-17-1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | | BALTO. | U.S. |

13. FATHER'S NAME: LEWIS KURTZ

14 MOTHER'S MAIDEN NAME: ELIZABETH, dau. PARKER

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | HOSPT. REC. | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Stroma

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: About 4 2 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 12 yrs ago | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible] *to* [illegible], 19[illegible] *that I last saw the deceased alive on* [illegible], 1949, *and that death occurred at* 2:00 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| [illegible] M. D. | [illegible] | [illegible] |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-12-1949 | DRUID RIDGE | PIKESVILLE MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | H. W. JENKINS & SONS CO. | 4905 YORK RD. |

VS 150

49a

Correct age is especially important. Physicians, please write the causes of death clearly and legibly.

G80738 22896 ✓X 54.6 G80768

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stewart Harvey
2. DATE OF DEATH: Dec 10, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland 1242 - 2nd.
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE M.D.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cooperstown
D. STREET ADDRESS (If rural, give location): R.D. 3
8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | 7-18-49 | 11 weeks | 22 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | New York | |

13. FATHER'S NAME: Henry Harvey
14. MOTHER'S MAIDEN NAME: Margaret Hoxson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cardiac Failure | 6 hrs. |
| DUE TO (B) | Transposition of Great Vessels | Congenital |
| (C) | | |

19A. DATE OF OPERATION: 12/10/49
19B. MAJOR FINDINGS OF OPERATION: Transposition of Great Vessels
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5-49 *to* 12-10-49 *that I last saw the deceased alive on* 12-10-49 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Shubael F. Griffith M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 12/10/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Dec 12/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Ulman Funeral Home 2008 Orleans

VS 150

157E

G80739

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80739

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George E. Webster

2. DATE OF DEATH: Dec 10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.S.G. University Hosp.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02
D. STREET ADDRESS (If rural, give location): 522 Washington Blvd

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): divorced
8. DATE OF BIRTH:
9. AGE (In years last birthday): 58 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10B. KIND OF BUSINESS OR INDUSTRY: grocery
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Max Webster
14. MOTHER'S MAIDEN NAME: Hattie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 216-07-5758
17. INFORMANT: Edgar Webster ADDRESS: 1735 E 25th St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 11 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/13/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Olivet
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ulman Funeral Home ADDRESS: 2008 Orleans

VS 151

138

C80740 ✓ 330

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80740

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Alexander Dates

2. DATE OF DEATH 12-9-48

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 16
D. STREET ADDRESS (If rural, give location) 822 N. Carrollton Ave

5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH April 21 1870 | 9. AGE (In years last birthday) 79 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Retired | 10B. KIND OF BUSINESS OR INDUSTRY Insurance | 11. BIRTHPLACE (State or foreign country) Virginia | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Alexander Dates | 14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT Mrs Alice Dates | ADDRESS 822 N. Carrollton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident (Subarachnoid Hemorrhage) — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-7-1948 *to* 12-9-1948, *that I last saw the deceased alive on* 12-9 1948, *and that death occurred at* 11 5 m. *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D. | 23B. ADDRESS [illegible] | 23C. DATE SIGNED 12-9-48

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-18-48 | 24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem. | 24D. LOCATION (City, town, or county) Baltimore, (State) Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 12 1948 | REGISTRAR'S SIGNATURE Huntington Williams M.D. | 25. FUNERAL DIRECTOR Mrs. Frances A. Kemp & W. Biddle | ADDRESS 578

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

G80741

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. G80741

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Henri Gere

2. DATE OF DEATH Dec 10, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 3506 Copley Rd.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3506 Copley Rd

c. Length of stay in Baltimore 10 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE 3506 Copley Rd Balto Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto, Md, 15-11
D. STREET ADDRESS (If rural, give location) 3506 Copley Rd Balto Md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | March3,1864 | 85 | 9 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | France | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Gilbert Gere | Marie |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | No | No | Mr. S.F. Pike | #3506 Copley Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) C.V. disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9/22/48, 19__, *to* 12/10, 19 49, *that I last saw the deceased alive on* 12/10, 19 49, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Daniel Wilson M. D. | 5721 Reisterstown Rd | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec.12,1949 | Druidridge Cemetery | Reisterstown Rd. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | David Sondheim & Son | 1902 Eutaw Pl |

David Sondheim Son

93D

V8 150

Correct age is especially important. Physicians, please state the causes of death clearly and fully.

G80742

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

174 Registered No. G80742

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FANNY Sondheim 4445-89

2. DATE OF DEATH: DEC 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 1621 Bolton St. 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | M. | 5-8-81 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| house wife | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Berney | Theresa Hamburger |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis, generalized

DUE TO

(B) Carcinoma of sacral atrus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: L.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct 1949 | Extensive cancer. Sarcoma of atrus | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-6-, 1949 *to* 12-11-, 1949 *that I last saw the deceased alive on* 12-11-, 1949, *and that death occurred at* 5. A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edmund R. Brook M. D. | JOHNS HOPKINS HOSPITAL | 12/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 12-12-49 | Loudon Park. | Frederick Road. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | David Sond Leem & Son. | |

VS 150

48B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80743

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80743

1. NAME OF DECEASED (Type or Print): Mabel M. Rose 202441

2. DATE OF DEATH: DEC 11 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Talbot
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Easton
D. STREET ADDRESS (If rural, give location): 3 Atkins Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | Under 1 Year: Months | Days | Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | S. | 2-13-81 | 67 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired Teacher | | N.Y. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Percy Rose | Connie Robinson |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Coronary artery sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-4- 1948 *to* 12-11- 1949 *that I last saw the deceased alive on* 12-4- 1949, *and that death occurred at* 12.43 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert Paine M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 13. 1949 | Woodlawn Cemy. | New York. N.Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Washington Williams, M.D. | John B. Mitchell Sons | 1800 Eutaw Place |

VS 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SOSNOVSKY

G80744

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 840. G80744 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Leon Sosnovsky — N-803.2

2. DATE OF DEATH: 12-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18 03
D. STREET ADDRESS (If rural, give location): 1046 West Lombard St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: 10 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | 2 | 70 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Packer

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Kaftally

14. MOTHER'S MAIDEN NAME: Jessie Sosnowsky

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Amelia ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of Skull c

DUE TO

(B) Intracranial Hemorrhage

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public (street)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Balto. & Stockton Sts.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: December 10, 1949 12:05p

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?: Ped. struck by trackless trolley

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Earl L Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒

23C. DATE SIGNED: 12-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-12-49

24C. NAME OF CEMETERY OR CREMATORY: Alfred Mt Carmel

24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Pl

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

171 C

G80745

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

198 - 1 G80745
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Sollod

2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

c. Length of stay in Baltimore: 45 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-A
D. STREET ADDRESS (If rural, give location): 1531 E Monument St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | Candy | Russia | |

13. FATHER'S NAME: Benjamin

14. MOTHER'S MAIDEN NAME: Blumer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Pauline Sollod | 1500 E Monument St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized peritonitis — DUE TO

(B) Perforated stomach — DUE TO

(C) Generalized lymphosarcoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/1, 1949, *to* 12/11, 1949, *that I last saw the deceased alive on* 12/11, 1949, *and that death occurred at* 11:35 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arlyn H. Wood M. D. | West Balt. General Hospital | 12/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-12-49 | Rosedale | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Jack Reevis Inc | 2100 Eastern Ave |

VS 150

4613

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80746

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

19 3

Registered No. G80746

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jeanette L. Schmidt

2. DATE OF DEATH: 12-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 12, Md
D. STREET ADDRESS (If rural, give location): 4218 Evanhoe Ave 27-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 9-28-43 | 6 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Maryland | USA |

13. FATHER'S NAME: Woodrow Wilson Schmidt

14. MOTHER'S MAIDEN NAME: Helen Kummrow

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Mother + father | above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Neuroblastoma | 3 mos. |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Sept, 1949, *to* Dec 9, 1949 *that I last saw the deceased alive on* Dec 9, 1949, *and that death occurred at* 8:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Donald B. Bond M. D. | Union Memorial Hosp | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 12-13-49 | Moreland Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | John A. Moran | 3000 E. Balt. St. |

54B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80747

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 G80747

Registered No.

1. NAME OF DECEASED (Type or Print) Annie Gross

2. DATE OF DEATH 12-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-0
D. STREET ADDRESS (If rural, give location) 125 - N. Schroeder

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | 4/8/1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Domestic | Middlesex County, Va | U. S. C. |

13. FATHER'S NAME Thomas Gwynn

14. MOTHER'S MAIDEN NAME Margaret Holmes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Georgianna Gross (D) | 125 N. Schroeder St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Glomerulonephritis

DUE TO Generalized Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-22, 1949, to 12-8, 1949, *that I last saw the deceased alive on* 12-8, 1949, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. E. Brady M. D. | Provident Hosp | 12-8 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 12/49 | Arbutus Memorial Pk | Balto County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Chas Harper | 512 Carrollton Ave |

VS 150

131a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80748

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160

Registered No. G80748

BIRTH NO. 49-26723

1. NAME OF DECEASED (Type or Print): STEPHEN BERNARD SENKUS

2. DATE OF DEATH: 12-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTIMORE MD
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 19 34
D. STREET ADDRESS (If rural, give location): 216 S. VINCENT ST 23

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | S | 12-9-49 | | | 12 05 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MD | |

13. FATHER'S NAME: BENJAMIN CASIMIR SENKUS

14. MOTHER'S MAIDEN NAME: CATHERINE [illegible] MILESKY

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Benjamin Senkus 216 S. Vincent St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial hemorrhage. DUE TO tentorial tear.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12-9, 1949 to 12-10-, 1949; that I last saw the deceased alive on 12-10, 1949; and that death occurred at 12:30P m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John C Mallen M. D. | Bon Secours Hosp. Baltimore | 12-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Holy Redeemer Cem | Belair Rd Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, MD | Joseph Kaesmakers Jr. | 602 Wash. |

VS 150

160a Bene

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80743

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80749

Registered No.

1. NAME OF DECEASED (Type or Print) Alice M. Trainer

2. DATE OF DEATH 12/10/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balt. General Hosp

c. Length of stay in Baltimore Yrs. 1 Mos. 10 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY, Baltimore
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Owings Mills
D STREET ADDRESS (If rural, give location) Deer Park Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | DIVORCED | | 67 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWORK. | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| THOMAS F. SHIELDS | REBECCA ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | J. VERNON TRAINOR 3707 EDGEWICK ROAD SILVER SPRINGS |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction & hypertension, Arteriosclerotic cardiovascular disease
DUE TO (B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/11, 1941, to 12/10, 19 49 *that I last saw the deceased alive on* 12/10 1949 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arthur H. Wood M. D | west Balt. General Hosp | 12/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 13/49 | Loudon Park | Frederick Road Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 7 1949 | Evelyn Williams, M.D. | Eustace E. Donovan | 3818 Roland Ave |

VS 150

93D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80750

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80750 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Tillie J. Townsend.

2. DATE OF DEATH: Dec 11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3625 Coolidge Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-41
D. STREET ADDRESS (If rural, give location): 3625 Coolidge Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | widow | Dec 31 1871 | about 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Maryland | |

13. FATHER'S NAME: Levin Harris

14. MOTHER'S MAIDEN NAME: Matilda Brydue

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Esther J. Townsend | 3745 Elm Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic cardio vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ~~Coma~~ Cerebral thrombosis

DUE TO

(C) none

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mos / days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/15, 19 49 *to* 12/11, 19 49, *that I last saw the deceased alive on* 12/11, 19 49, *and that death occurred at* 6:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Wertle M. D. | 1830 Eutaw ave | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 14/49 | Sunny Ridge | Crofield, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Gustav E. Donovan | 3818 Roland Ave. |

VS 150

937

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80751 ✓ G80751

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward William McDowell

2. DATE OF DEATH: December 11, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 7½ yr. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 342 E. Federal 12-C5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | Colored | Single | MAR. 10, 1912 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MACHINE OPERATOR | CLEANERS & DYERS | S. Carolina | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edward McDowell | Gladys. ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 243-09-9375 | Ida McDowell | 342 E. Federal St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO

(B) Hypertensive Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 7, 1949 *to* Dec. 11, 1949, *that I last saw the deceased alive on* Dec. 10, 1949, *and that death occurred at* 6:43a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kaan M. D. | 1400 N. Caroline St. | December 11, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-14-49 | MT. CALVARY | A.A. County. Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

25. FUNERAL DIRECTOR: Joseph S. Rocks Jr. ADDRESS: 1304 E. Central Ave

VS 150

93D

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G80752

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-21-4

Registered No. G80752

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SUSAN TODD WELLS

2. DATE OF DEATH: Dec. 8, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3 E. Highfield Rd.

c. Length of stay in Baltimore: 25 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3 E. Highfield Rd. 12-01

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widow | Feb. 17, 1868 | 81 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Cox | Susan Cook |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. H. A. Wells | 3 E. Highfield Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Dilatation Heart — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Myo-Carditis — 20 yrs.

DUE TO

(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* [illegible] 1928 *to* Dec 8, 1949 *that I last saw the deceased alive on* Dec 8, 1949 *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert M. Foster M. D. | 282 St. Paul St. | Dec 9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 12/12/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Curtis Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80753

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80753

1. NAME OF DECEASED (Type or Print): Edwin J. Foxwell, Sr.

2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 601 N. Clinton St.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 601 N. Clinton St. 26-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 19, 1899 | 50 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| wireman | Gas & Elec. | Balto., Md. | |

13. FATHER'S NAME: Charles Foxwell

14. MOTHER'S MAIDEN NAME: Catherine Carey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Cornelia G. Foxwell | 601 N. Clinton |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Wm. H. Kammer Jr. M.D

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: Dec. 10, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | Balto. Cem. | Balto., Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

G80754

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

581.0 Registered No. G80754

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH JOHN LITZ, Sr.

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 659 W. Fayette St. 4-a

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar. 30, 1895
9. AGE (In years last birthday): 54 yrs. (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: City Sanitary Dept.
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph J. Litz
14. MOTHER'S MAIDEN NAME: Yetta Wick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Gordon J. Fink ADDRESS: 1146 Scott St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cirhosis of Liver

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: Dec. 10, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/13/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

1242

Please write clearly with ink. Use no abbreviations. If unknown, state so. Do not leave blanks. Be sure to give correct age in years. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G80755

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 J-6

G80755

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): John G Berger

2. DATE OF DEATH: December 9 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5506 Fairoaks Ave.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6006 Pinehurst Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Mar. 17, 1873 | 76 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Boiler maker (rtd) | Railroad | Baltimore, Md. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mrs. Ethel B. Munro | 6006 Pinehurst Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Parkinson's disease — DUE TO — 2 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral arteriosclerosis — DUE TO — ?

(C) Generalized arteriosclerosis — ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Uterine hypertension

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Dec , 1947 *to* Dec , 1949, *that I last saw the deceased alive on* Dec 6, 1949 *and that death occurred at* 7:20? *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frederick D. Wellmer M. D. | 6100 York Road | Dec 10 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/13/49 | Chestnut Grove Cem. | Marysville, Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

87c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80756

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. | Registered No. G80756

1. NAME OF DECEASED (Type or Print): Scheuerman, Mrs Elizabeth
2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home & Hosp.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dundalk 22
D. STREET ADDRESS (If rural, give location): 1905 Washington Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Aug 22 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Skuhr, Frederick
14. MOTHER'S MAIDEN NAME: Myer, Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Leona Vincel ADDRESS: 1149 N. Haven St. Balto.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Infarction | 24 hrs |
| DUE TO (B) | Arteriosclerotic Cardio-Vascular Disease | 15 yrs. |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 5, 1949 *to* Dec 9, 1949 *that I last saw the deceased alive on* Dec 9, 1949, *and that death occurred at* 8:20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Ronald L. Craton M. D.
23B. ADDRESS: Church Home & Hosp.
23C. DATE SIGNED: Dec 9, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 13 DEC. 1949 | OAK LAWN | EASTERN AVE. BALTO. Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR: Walter Burke Bradley ADDRESS: 937 Dundalk, Balto. 22, Md

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G807-57 Wild. Express Case Released to Hosp. ✓Body Rec'd 12/10/49 P m

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH E 916

Registered No. G80757

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Sudler — N-948-?

2. DATE OF DEATH: December 7, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — John Hopkins Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: Md.
B. COUNTY: 6 - a
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1723 Orleans St.

5. SEX: Male | 6. COLOR OR RACE: Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3-79 | 9. AGE (In years last birthday): 70 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Upper Fairmount Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Freeford G Sudler

14. MOTHER'S MAIDEN NAME: Suby ?

15. HAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S ADDRESS: Freeford G Sudler for Washington D C

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) 2° & 3° burns of trunk varus 4 days
DUE TO 60% of body

(B)
DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R B Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Hypertensive cardiovascular disease ?

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ACCIDENT

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1723 ORLEANS ST. BALTO

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12-9-49 6 P m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? KEROSENE LAMP EXPLOSION 6/5

22. I hereby certify that I attended the deceased from 12-4, 1949, to 12-7, 1949, that I last saw the deceased alive on 12-7, 1949, and that death occurred at 1.45 P m., from the causes and on the date stated above.

23A. SIGNATURE: Paul C. Wilson M. D.

23B. ADDRESS: J H H.

23C. DATE SIGNED: 12-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): 12/13/49

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery

24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Christopher Williams M.D.

25. FUNERAL DIRECTOR: Robert Michaux

ADDRESS: 1515 Mt Elderry

VS 150

To be approx by Med. Exam.

181

correct age is especially important. Physician: please write the causes of death clearly and legibly.

G80758

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

491 G80758

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Rose Marie Kaiser

2. DATE OF DEATH: 12-11-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2407 Mayfield Ave

c. Length of stay in Baltimore: 48 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-01
D. STREET ADDRESS (If rural, give location): 2407 Mayfield Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 4-6-1901 | 48- | 8+5 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam Kaiser

14. MOTHER'S MAIDEN NAME: Mara Krenger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs Mara Kaiser ADDRESS: 2407 Mayfield Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO associated

(B) Kyphosis & lordosis spine

DUE Congenital heart disease & acute myocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) Congenital malformation of extremities & atrophy

19A. DATE OF OPERATION: ~~—~~

19B. MAJOR FINDINGS OF OPERATION: ~~—~~

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): ~~—~~

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 18, 1949 *to* Dec. 11, 1949 *that I last saw the deceased alive on* Dec 10, 1949 *and that death occurred at* 6 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: H. H. Harbold M.D.

23B. ADDRESS: 4706 Harford Road

23C. DATE SIGNED: Dec 12, 1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-13-49

24C. NAME OF CEMETERY OR CREMATORY: Most Holy Redeemer

24D. LOCATION (City, town, or county): Baltimore (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Elmer W. Coulbourn ADDRESS: 924 E. Eager St.

VS 150

107

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80759

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

194-8 Registered No. C80759

1. NAME OF DECEASED (Type or Print): Lula Connor

2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2730 Winchester St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE COUNTY: 2730 Winchester St
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 16-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | | Aug 29-1893 | 56 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | Grocery - | Baltimore Md | |

13. FATHER'S NAME: Louis Row

14. MOTHER'S MAIDEN NAME: Susan Elliott.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-22-7958

17. INFORMANT: Clara E. Talbott. ADDRESS 2730 Winchester St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Carcinoma — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 1937

19B. MAJOR FINDINGS OF OPERATION: Dr Stewart Evans abdomen [illegible] Transabdominal

20. AUTOPSY? Yes ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____ 19__, to Dec 11, 1949 that I last saw the deceased alive on Dec 11, 1949 and that death occurred at 12 p m., from the causes and on the date stated above.

23A. SIGNATURE: Myer A. Weinstein M. D.

23B. ADDRESS: 1724 Eutaw Place

23C. DATE SIGNED: 12-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried

24B. DATE: 12/14/49

24C. NAME OF CEMETERY OR CREMATORY: Louderman Park

24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Chas P. Towell ADDRESS: 2427 Edmondson Ave

VS 150

47D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80760

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80760

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mamie E. West

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1310 E Chase St

c. Length of stay in Baltimore: 8 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1310 E Chase St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | Col. | Married | May 25 1908 | 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Brandywine Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harry Washington | Lizzie Pinkney |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Andrew West 1310 E Chase St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Hypertensive Cardiovascular and renal disease — May 1949

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Dec 10, 1949, *that I last saw the deceased alive on* Dec 10, 1949 *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 1422 E. Chase St | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 13/49 | Brandywine Cem. | Brandywine Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams M.D. | Mrs Robert L. Elliott Daughter | 1310 1129 N. Carrie St. |

VS 150

correct age is especially important. Physician:—please write the cause of death clearly and legibly.

G80761

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80761

BIRTH NO. 49-28378 — Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): John Robert Scott A74858 | 2. DATE OF DEATH: DEC 11 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE: Md. B. COUNTY: Baltimore |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. |
| c. Length of stay in Baltimore: Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location): 508 Meadow Road. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | S. | 12-9-49 | | 1 | 5 7 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert S. Scott | Evelyn |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity — (Interval between onset and death)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-10- 1949 *to* 12-11- 1949, *that I last saw the deceased alive on* 12-11- 1949, *and that death occurred at* 11 25 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison C. Jewett M. D. | JOHNS HOPKINS HOSPITAL | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/12/49 | Druid Ridge Cemetery | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Isaac J. Burke |

VS 150

159

Please write plainly. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

G80762

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 Registered No. G80762

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Benjamin Wallace

2. DATE OF DEATH: 12/9/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 652 Smithson Street

c. Length of stay in Baltimore: 50 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 652 Smithson Street 14-0 Y

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Col. | Married | March 22, 1893 | 56 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Howard County, Md. | |

13. FATHER'S NAME: Edward R. Wallace

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 219-01-1308

17. INFORMANT: Gertrude Wallace ADDRESS: 652 Smithson St., Balt, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio - Renal Disease — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

ANTECEDENT CAUSES

(B) Congestion

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | No | No |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | None |

22. *I hereby certify that I attended the deceased from* Dec. 8, 1949 *to* Dec. 9, 1949, *that I last saw the deceased alive on* Dec. 8, 1949 *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 1300 N. Fremont Ave. | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 12, 1949 | Mt. Calvary | Westport, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Joseph L. Russ | 1200 McCulloh Balt., Md. |

VS 150

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

ERTIFICATE CORRECTED 1-30-50

G80763

BIRTH NO.

# CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

E914.3 G80763 Registered No.

1. NAME OF DECEASED (Type or Print) RONALD ROLAND E. KRAUSE — 11-992

2. DATE OF DEATH December 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2638 Hampden ~~Road~~ Ave — 12-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Single | Sept 17 1932 | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stock Clerk. | Hutzler Bros. | Md. | |

13. FATHER'S NAME John C. Krause

14. MOTHER'S MAIDEN NAME Florence C. Cotter.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | | John C. Krause | 2638 Hampden Ave. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia due to electrocution — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | Came in contact ~~with~~ overhead current ~~and~~ while standing on boxcar | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Railroad yard | over Pa. R.R. coach yard B & O Trestle under North Ave. bridge 12/9 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 11, 1949 ?p m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | and fell to r.r. yard below ~~Stepped on electric third rail on tract~~ |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R. H. Fisher M.D. | | Dec. 12, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | New Cathedral | Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Washington Williams, M.D. | Paul E. Chenowith Jr. | 3615-17 Gwynns Falls |

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80764

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80764

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George F. Stitely

2. DATE OF DEATH: 12/1/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore MD
D. STREET ADDRESS (If rural, give location): 2402 Miles Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Oct 26 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| machinist | Autocar Co | Md. | |

13. FATHER'S NAME: George W. Stitely

14. MOTHER'S MAIDEN NAME: Sarah J. Martini

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | 216-10-0421 | Lula K. Stitely | 2405 Miles Ave. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Paralysis Cerebral

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| J. P. Lemmon M.D. | | 12/2/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Woodlawn | Woodlawn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12 1949 | Huntington Williams, M.D. | Paul E. Shemanski Jr. | 4547 Belair Rd |

VS 151

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80765 BALTIMORE CITY HEALTH DEPARTMENT G80765

# CERTIFICATE OF DEATH

174 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Pauline Frazier McCloud

2. DATE OF DEATH: 12-8-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (if not in hospital or institution, give street address or location): 906 Bevans St.
c. Length of stay in Baltimore: 36 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 906 Bevans St 2-01

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb 24 1913
9. AGE (In years last birthday): 36 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Whittington
14. MOTHER'S MAIDEN NAME: Mary Biggs
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: William A. Frazier ADDRESS 468 Monroe St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of uterus — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 10 1949, *to* Dec 8, 1949, *that I last saw the deceased alive on* Dec 8, 1949, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: David Crawder M. D.
23B. ADDRESS: 112 W Lee St
23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-12-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State): Baden Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
25. FUNERAL DIRECTOR: Wm. Peter R. Williams ADDRESS 822 N. Schroeder St.

48B

Please write plainly in ink. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. Correct age is especially important. Physicians: please write, the causes of death clearly and legibly.

G80766 49-27916 G80766

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

673

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Thelma Anderson E 954.8

2. DATE OF DEATH 12-8-'49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

C. Length of stay in Baltimore 16 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, Md. 18 ✓

D. STREET ADDRESS (If rural, give location) 1077 W. Fayette St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | Negro | Single | April 11, 1933 | 16 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10B. KIND OF BUSINESS OR INDUSTRY ?

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Anderson

14. MOTHER'S MAIDEN NAME ? Lula Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Florence Butler ADDRESS (above)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fetal Anastrecia — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

DUE TO given for c. section by

(B) contracted pelvis

DUE TO pt. died before operation began.

(C) Post mortem section done over

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 12-8-49

19B. MAJOR FINDINGS OF OPERATION Del 35 72 gm living male child

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9:00 PM 12-2, 19 49, *to* 10:35 PM 12-8, 19 49, *that I last saw the deceased alive on* 12-8, 19 49, *and that death occurred at* 9:37 *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature], M.D.

23B. ADDRESS [illegible]

23C. DATE SIGNED 12-8-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12-13-49

24C. NAME OF CEMETERY OR CREMATORY W. Auburn Cem.

24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 12 1949

REGISTRAR'S SIGNATURE [signature]

25. FUNERAL DIRECTOR Wm. Kelly R. Williams ADDRESS [illegible]

VS 150

149B

G80767

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

154 G80767 Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 579 N. OXFORD ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 -YRS.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State MD. (b) County
(c) City or town Balto. 17-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 579 N. OXFORD ST.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

**3 (a) FULL NAME** Charles SKates

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | MARRIED |

6 (b) Name of husband or wife Estelle SKates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-1-1889

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | | | hr. min. |

9. Birthplace BROOKNAIR V2.
(Town, county, and state)
10. Usual Occupation UNemployED
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace V2

MOTHER
14. Maiden Name Jennie Coleman
15. Birthplace V2.

16 (a) Informant Estelle SKates
(b) Address 579 N. OXFORD ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-14-49 (month) (day) (year)
(c) Cemetery ~~or crematory~~ MT. CalvARY
Location CedaR Hill MD.

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave.

DEC 12 1949 (a) (b) Registrar

VS 150

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH 12-11 1949 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1949 to Dec 11 1949, and that I last saw h[illegible] alive on Dec 11 1949.

| Immediate cause of death | Duration |
|---|---|
| Carcinoma of Eye Lung and Rectum | ? |
| Due to | |
| Due to | |
| Other Conditions | |

(Include pregnancy within 3 months of death)
Date of operation Oct 1949 None
Major findings of operation:
Biopsy all Carcinoma
of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 404 N. Fulton Ave Date signed 12/12/49

46D

G80768 ✓ E90.0

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80768

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS MARY SCHWARZKOPF — N-821-0

2. DATE OF DEATH 12/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Md. Gen Hosp.

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 623 E Biddle st #2 — 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Jan 8 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H W | — | Va | USA |

13. FATHER'S NAME Oswald Lynn

14. MOTHER'S MAIDEN NAME Mary Faulkner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Occlusion | 2 hr |
| DUE TO | | |
| (B) | Fracture upper ⅓ rt femur | 16 days |
| DUE TO | | |
| (C) | Diabetes Mellitus | 1 yr |

CERTIFICATION APPROVED BY

for: C. J. Lubinski, M. D.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If outside Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | 623 E Biddle st 10/1 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11/24/49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Fell down step |

22. *I hereby certify that I attended the deceased from* 11/24 194- *to* 12/10 1949 *that I last saw the deceased alive on* 12/10 1949, *and that death occurred at* 7:35 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Maryland General Hosp. | 12/10/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Dec 2/49 | Loudon Park | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 12 1949 | [signature] | Rita Wiedefeld 900 E. Biddle |

VS 150

186a

FOR USE OF PHYSICIAN ONLY. WHEN UNKNOWN, SO STATE. EVERY ITEM OF INFORMATION SHOULD BE GIVEN. Be sure that the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80769

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

78 v. 4

Registered No. G80769

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary C. Steinmann

2. DATE OF DEATH: Dec. 10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3805 St. Paul St.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3805 St. Paul St. 12-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: Nov. 14, 1854
9. AGE (In years last birthday): 95 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Conrad Weidhardt
14. MOTHER'S MAIDEN NAME: Marie Lehr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Karl F. Steinmann, ADDRESS: 3805 St. Paul St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senility
DUE TO
(B)
DUE TO
(C) Myocardial failure. — INTERVAL BETWEEN ONSET AND DEATH: 6 years

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1 — , 1949 *to* Dec 10 , 1949 *that I last saw the deceased alive on* Dec. 10 , 1949 *and that death occurred at* 5 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: George A. Bawden M. D.
23B. ADDRESS: 323 Medical Bldg
23C. DATE SIGNED: 12/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 13/49
24C. NAME OF CEMETERY OR CREMATORY: London Park
24D. LOCATION (City, town, or county) (State): 3801 Frederick Rd. Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: [illegible] Williams M.D.
25. FUNERAL DIRECTOR: Harry H. Wittle
ADDRESS: 4101 Edmondson Ave.

162 B

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C807.0

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C807.0

Registered No. 91360

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARDS, ANNIE MAY

2. DATE OF DEATH: Dec. 7, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital, Wyman Park Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 10 S. Bond St. 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Married | Unknown | ? 41 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | North Carolina | USA |

13. FATHER'S NAME: Lonnie O'Neal

14. MOTHER'S MAIDEN NAME: Viola Brown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | Unknown | Records, U.S. Marine Hospital, Balto. Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | | |
| (A) DUE TO | Scleroderma generalized with involvement of heart, kidneys, serous surfaces | Approx. 2 yrs. |
| (B) DUE TO | | |
| (C) | Hypostatic pneumonia, slight | Unknown |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Sept. 29, 1949 | Biopsy Findings - Scleroderma | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Sept. 21, 1949 *to* Dec. 7, 1949 *that I last saw the deceased alive on* Dec. 7, 1949 *and that death occurred at* 5:35 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | U.S. Marine Hospital, Balto, Md | Dec. 8, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 14 | Mt Calvary Cemetery | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 12 1949 | Huntington Williams M.D. | Edwin O Williams |

VS 150

153 1000 Brantley Rd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80771 ✓ 20.1 G80771

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | MARGARET MARY PORCELLA | 2. DATE OF DEATH | Dec. 10, 1949 |

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2323 E. Milliman St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2323 E. Milliman St. 7-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Jan. 31, 1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Patrick Rooney | Mary Sadler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Jos. A. Porcella, 3007 McElderry St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardio
DUE TO Vascular Disease
(B)
DUE TO Acute Coronary Occlusion
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 17 yr.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| None | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan / 19 , to Dec 10, 19 49, *that I last saw the deceased alive on* Dec 9, 19 49, *and that death occurred at* 3 30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. Fred Rugicka M. D. | 600 N. Patterson Park Ave | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | Holy Redeemer Cem. | 4430 Belair Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 150 (F. Fred Rugicka) 93D

G80772

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1743 Registered No. G80772

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Felix A. Logue
2. DATE OF DEATH: 12/9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2317 E. Madison St.,
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 67 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. 2317 E. Madison St.
B. COUNTY: 7-03
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Aug 2,1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireboat | Fire Department | Baltimore, Md. | U.S. |

13. FATHER'S NAME: John Logue
14. MOTHER'S MAIDEN NAME: Mary Ann Kielly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| no | none | Carrie M. Logue (wife) 2317 E. Madison |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive cardiovascular disease. | March 194 |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* March 28, 1949 *to* Dec. 9, 1949, *that I last saw the deceased alive on* Dec. 9, 1949, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. Schmick M. D. | 701 N. Kenwood Ave. | 12/9/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | New Cathedral | Edmondson Ave., Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | Schimunek Funeral Home 2601 E. Madison St. |

VS 150

937

CERTIFICATE CORRECTED 12-12-49 ✓

G80773

G80773

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rosa De Dominicis ~~De Dominicis~~ De Dominicis

2. DATE OF DEATH Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore 55 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2621 E. Madison St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Dec. 5, 1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Italy

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Dominic Appugliese

14. MOTHER'S MAIDEN NAME Clorinda Manella

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Theodora DeDominicis, 2621 E. Madison St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 11 days |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive Cardiovascular Disease Several years | |
| DUE TO | | |
| | (C) | |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1949, *to* Dec 10, 1949, *that I last saw the deceased alive on* Dec. 10, 1949, *and that death occurred at* 3 20 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Clifford T. Riddel Jr. M. D.

23B. ADDRESS Mercy Hospital

23C. DATE SIGNED 12-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/14/49

24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.

24D. LOCATION (City, town, or county) (State) 4430 Belair Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 12 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80774

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E902.0 G80774 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH PUROL — N803.2

2. DATE OF DEATH: December 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2231 Bank Street

C. Length of stay in Baltimore: 57 Years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2231 Bank Street — 105

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | March 15 1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Poland | U.S.A. |

13. FATHER'S NAME: Purol

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 215-22-4467 | Mrs. Mary Lijewski Daughter | 2231 Bank St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured skull — INTERVAL BETWEEN ONSET AND DEATH: ONCE
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 2231 Bank Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 9, 1949 ?A.M. | | Fell from second story window |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| D. J. Thuringer M.D. | | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 13 1949 | Holy Rosary Cem. | Balto. County |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, MD | John M. Welsh | 401 S. Chester St |

VS 151

6/10/1-99

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80775

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80775

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert T. Reiman) (RIEMAN)

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 748 McHenry St. 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | OCT 25 1891 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PAINTER. | B&O R.R. | Baltimore Md | USA |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes, 1st World War | 217-03-7962 | Lillian Timmel 748 McHenry St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Coronary Artery Disease -

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, [redacted] ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | M.D. | 23B. MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| Earl L Rose | | | Dec. 10, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-14-49 | Baltimore National | Frederick Rd Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 12 1949 | Huntington Williams, MD | Charles H Jackson |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

93D

6807.6

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 116 Registered No. 6807.6

1. NAME OF DECEASED (Type or Print): Mary Anna Yoos Jugintowicz

2. DATE OF DEATH: Dec 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 830 S. East Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 830 S. East ave 26 11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widow | Aug 13 1889 | 60 62 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Lizak
14. MOTHER'S MAIDEN NAME: Mary ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Walter Yoos ADDRESS: 830 S. East ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Bronchopneumonia | 24 hours. |
| DUE TO (B) | Rheumatic C.V.D. | 20 yrs.? |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/17 *,* 1948 *to* 12/10 *,* 1949 *, that I last saw the deceased alive on* 12/10 *,* 1949 *and that death occurred at* 825 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: J. Karl Grossman M. D.
23B. ADDRESS: 1212 N Patterson Park Ave
23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 14 1949
24C. NAME OF CEMETERY OR CREMATORY: St Stanislaus Cem.
24D. LOCATION (City, town, or county) (State): Balto City

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John H. Weber ADDRESS: 401 S. Chester street

93c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80777

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registration No. 7797

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 820 Woodyear St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 15-01
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Woodyear St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

**3 (a) FULL NAME** Lucinda Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife Samuel Stokes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-1890

8. AGE: Years 59 Months Days If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jack Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Wanza
15. Birthplace Va.

16 (a) Informant Samuel Stokes
(b) Address 820 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/49 (month) (day) (year)
(c) Cemetery or crematory Brookland, Virginia
Location Va.

18 (a) Funeral director Mc. H. Kelson
(b) Address 1313 Pennsylvania Ave

DEC 12 1949 (Date rec'd by registrar) (b) Langston Williams, Registrar

VS 150

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1949 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2- 1949 to 12-10- 1949 and that I last saw her alive on 12-9- 1949

Immediate cause of death Pulmonary T.B. Duration 8 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George C. Page
Address 1816 Monument St (17) Date signed 12/12/49

13B

C80778

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59 Registered No. C80778

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK ALEXANDER BELL

2. DATE OF DEATH: Dec. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5408 Reisterstown Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
a. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 5408 Reisterstown Rd. 28 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | May 7, 1905 | 44 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Assistant Cashier | Bank | Md. | |

13. FATHER'S NAME: John Bell

14. MOTHER'S MAIDEN NAME: Edith C. Winkleman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Frank A. Bell | 5408 Reisterstown Rd. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Chronic nephritis, bilateral | About 8 years. |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Pyelonephritis, bilateral | Unknown. |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No. | No. | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June, 19 47 *to* Dec 9, 19 49, *that I last saw the deceased alive on* Dec. 9, 19 49 *and that death occurred at* 7 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jas G. Hayes Jr. M. D. | 11 E. Chase Street | 12.12.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/13/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Lucretia [illegible] Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

1218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80779

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

53

BIRTH NO. G80779 Registered No.

1. NAME OF DECEASED (Type or Print): ANN TAFT RODMAN

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31 St.

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Brooklyn)
D. STREET ADDRESS (If rural, give location): 1009 Jack Place

25-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 2/6/02 | 47 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwf.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ky.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Claude Duvall

14. MOTHER'S MAIDEN NAME: Mildred Peffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Records- US Marine Hospital, Balto, Md. ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adenocarcinoma of colon with metastasis to abdominal lymph nodes left adrenal and liver.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: More than 1 yr.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 5, 1949, *to* Dec. 11, 1949, *that I last saw the deceased alive on* Dec. 11 1949, *and that death occurred at* 10:55PM *from the causes and on the date stated above.*

23A. SIGNATURE: D.W. Patrick, Medical Director M. D.

23B. ADDRESS: US Marine Hospital, Balto, Md.

23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12/12/49

24C. NAME OF CEMETERY OR CREMATORY: Frankford Cem.

24D. LOCATION (City, town, or county) (State): Frankfort, Ky.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949

REGISTRAR'S SIGNATURE: Hunter Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

46E

G80780

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80780

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): WILLIAM H. MURR, Jr.

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 24 E. Madison St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 24 E. Madison St.

11-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 24, 1896 | 53 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| clerk | sugar refinery | Chester, S. C. | |

13. FATHER'S NAME: -

14. MOTHER'S MAIDEN NAME: Elizabeth Eagle

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| yes World War #1 | 219-01-3635 | Mrs. Grace C. Murr | 24 E. Madison St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of sigmoid | 6 mos. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Generalized Carcinomatosis | 1 month |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| ? | Carcinoma of sigmoid | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 1949 *to* Dec. 11, 1949 *that I last saw the deceased alive on* Dec 11, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Daniel R Robertson M. D. | 2835 Fairmount Ave Balto | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Removal | 12/13/49 | - | Chester, S. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Washington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46E

G80781

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

57 10.5

BIRTH NO.

Registered No. G80781

1. NAME OF DECEASED (Type or Print): John Kenny

2. DATE OF DEATH: 12-10-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balt: more 27 - 17
D. STREET ADDRESS (If rural, give location): 5309 Ethelbert St.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married.
8. DATE OF BIRTH: Nov. 19, 1869
9. AGE (In years last birthday): 80 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: Md Trust Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Margaret Y. Kenny ADDRESS: 5309 Ethelbert

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bowel Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO etiology undetermined

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-9- 1949, *to* 12-10- 1949, *that I last saw the deceased alive on* 12-10- 1949, *and that death occurred at* 4 40 p *m., from the causes and on the date stated above.*

23A. SIGNATURE: S. D. Thomas M. D.
23B. ADDRESS: Mercy Hosp.
23C. DATE SIGNED: 12-10-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 13 '49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Forney Byers ADDRESS: 500 Pk Ave

VS 150

122B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80782

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80782 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JANE M. BEYER

2. DATE OF DEATH: 12-9-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 329 E. 24th Street
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 329 East 24th Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1903 | 46 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home
10B. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Meers
14. MOTHER'S MAIDEN NAME: Laura Lemmon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no / -
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. H.C.Beyer ADDRESS: 329 East 24th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular disease - Nephritis. — INTERVAL BETWEEN ONSET AND DEATH: 5 years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan - 1 - 1949 *to* 12-9- 1949, *that I last saw the deceased alive on* 12-9- 1949, *and that death occurred at* 8:45 m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 715 North Charles St | 12-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-13-49 | Balto. Nat'l Cem | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Huntington Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

S. DeMARCO

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

M M. G80783

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C-70783

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Cora, Johns

2. DATE OF DEATH: Dec. 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City, Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 25, Years (Yrs.) (Mos.) (Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 29 S. Caroline ST. Z 31 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widow | Mar. 26, 1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: (D)
14. MOTHER'S MAIDEN NAME: (D)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Records B.C. H. ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion?
DUE TO
(B) Possible Pulmonary Edema?
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5- , 1949, *to* 12-9- , 1949, *that I last saw the deceased alive on* 12-9- 1949, *and that death occurred at* 2.13 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: 12-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-13-49
24C. NAME OF CEMETERY OR CREMATORY: Johns Family Cem.
24D. LOCATION (City, town, or county) (State): Prince George Co. Va

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: [signature] Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. O. Wilson
ADDRESS: 1009 Brantley Ave

VS 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr R Burton

G80784

G80784

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 410

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Major Hewlett

2. DATE OF DEATH: 12/10/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): II North Bond Street

c. Length of stay in Baltimore: 20 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): II North Bond Street 6-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Married | Sept. 19th. 95 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steveadoor
10B. KIND OF BUSINESS OR INDUSTRY: Longshorman Buis.
11. BIRTHPLACE (State or foreign country): Ashland Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Unkown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): Ware # 1
16. SOCIAL SECURITY NO.: 213-03-3412
17. INFORMANT: Marie Hewlett ADDRESS: II North Bond Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Valvular insufficiency (aortic + mitral) | ? |
| DUE TO (B) | | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | hypertensive cardio-renal Disease | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/7 1949 *to* 12/10 1949 *that I last saw the deceased alive on* 12/7 1949 *and that death occurred at* 10 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature]
23B. ADDRESS: 1500 E. Madison St Balto.
23C. DATE SIGNED: 12-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-14-49
24C. NAME OF CEMETERY OR CREMATORY: Balto. Nat.
24D. LOCATION (City, town, or county) (State): Balto. City

DATE RECEIVED BY LOCAL REGISTRAR: DEC 12 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Chas O. Wilson
ADDRESS: 1000 Brantley ave

92 B

C80785 — John N. Knight — C80785

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 168676

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. John N. KNIGHT

2. DATE OF DEATH: 12-9-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20
D. STREET ADDRESS (If rural, give location): 412 Lyndhurst St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | 8-10-1886 | 63 | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | Davidson Chemical Co | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George R. Knight | Rose M. Connelly |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | | Adah A. Knight | 412 Lyndhurst St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hepatoma c metastasis | Unknown |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (C) | Coronary Insufficiency - Pleura Effusion | Unknown |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-6-49 | Hepatoma - C metastasis | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-22, 1949 *to* 12-9, 1949 *that I last saw the deceased alive on* 12-9, 1949, *and that death occurred at* 10 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert B. McFadden | St Agnes Hospital | 12-10-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 13-49 | New Cathedral | Balto. 29-Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 12 1949 | Curtis [illegible] Williams, M.D. | F. B. Wippert & Son | 1300 Eutaw Pl. |

VS 150

46F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# CERTIFICATE CORRECTED

G80786

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

G80786 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY S. LINCOLN

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2944 W. North Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2944 W. North Ave. 15-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 22, 1887 | 62 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter & Musician | Loyola College | Illinois | |

13. FATHER'S NAME: Jackson Lincoln

14. MOTHER'S MAIDEN NAME: Lottie (Unknown)

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | W.W.I | | Mrs Anna M. Lincoln | 2944 W. North Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary thrombosis | 1 day |
| DUE TO (B) | Coronary arteriosclerosis | 10 years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NONE | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 4, 1949, *to* Dec. 11, 1949, *that I last saw the deceased alive on* Dec. 9, 1949, *and that death occurred at* 3:00 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Abraham B. Hurwitz M. D. | 3048 W. North Ave. | Dec. 13, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 12/13/49 | Green Mount | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949

REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.

25 FUNERAL DIRECTOR: William Cook, Inc., 1217 St. Paul St.

ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

940

G80787

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80787 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Kalal / KALAL

2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 706 N. Stroeper St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 7-01
D. STREET ADDRESS (If rural, give location): 706 N. Stroeper St

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, ~~MARRIED~~, WIDOWED, DIVORCED (specify): Single
8. DATE OF BIRTH: May 12. 1873
9. AGE (If years, last birthday): 76 — If under 1 Year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: U. S. Stewart Co
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Kalal
14. MOTHER'S MAIDEN NAME: Josepha (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, ~~no~~, unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Michael J. Kalal — ADDRESS: 706 N. Stroeper st.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C. V Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: S. P. Sulzinske M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12/12/49

24A. BURIAL, ~~CREMATION, REMOVAL (specify)~~: Burial
24B. DATE: 12/14/49
24C. NAME OF CEMETERY ~~OR CREMATORY~~: Redeemer
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR: Wm Cook Jr. — ADDRESS: 1217 St. Paul St.

VS 151

93)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80788

G80788

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

344 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELLA VIRGINIA FRIZZELL ?

2. DATE OF DEATH: Dec. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4901 Crowson Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4901 Crowson Ave. 2 7 - 11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Oct 2. 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore County, Md. | |

13. FATHER'S NAME: George O. Nagel

14. MOTHER'S MAIDEN NAME: Martha Winters

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs Amy F. Leuderman | 4901 Crowson Road. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO
(B) Arterial hypertension — 15 yrs.
DUE TO
(C) Generalized arteriosclerosis — 15 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Carcinoma left breast (removed) — 18 mos.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* Dec, 1949, *that I last saw the deceased alive on* Dec 11, 1949, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frederick J. Vollmer M. D. | 6100 York Road | Dec 12 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | Mt Olivet | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC [illegible]

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR: William Cook, Inc. ADDRESS: 1217 St. Paul St.

VS 150

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80789

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

C80789

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) REBECCA HENDERSON

2. DATE OF DEATH Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3700 Oakmont Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3700 Oakmont Ave. 2-7-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | July 4, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore, Md. | |

13. FATHER'S NAME: James A. Hill

14. MOTHER'S MAIDEN NAME: Margaret Mitchell

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mrs. Eva Yaffe, 3700 Oakmont Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemmorhage
DUE TO
ANTECEDENT CAUSES
(B) Hypertension
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: (A) 1 day.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 2 *,* 19 41 *to* Dec 11 *,* 19 49 *that I last saw the deceased alive on* Dec 11 *,* 19 49 *and that death occurred at* m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton Liscomb M.D. | 1429 W Fayette St | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Moreland Memorial Park | Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 13 | | William Cook, Inc., 1217 St. Paul St. |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

83a

C80790 ✓ C80790

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH E97-0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FRANK J. REBSTOCK — N-961

2. DATE OF DEATH December 9, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 500 E. Fort Avenue — 2-4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | M | 10/18/1908 | 41 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frank Rebstock

14. MOTHER'S MAIDEN NAME Sarah E. Murphy ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give war or dates of service) WW#"2"

16. SOCIAL SECURITY NO.

17. INFORMANT Family - Same ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to

DUE TO inhalation of illuminating gas.

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) kitchen at 500 E. Fort Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) December 9, 1949 ?a m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Oven & gas burners on but unlighted

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Dec. 9, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) B

24B. DATE 12/13/49

24C. NAME OF CEMETERY OR CREMATORY Baltimore National

24D. LOCATION (City, town, or county) (State) 6501 Frederick rd.

DATE RECEIVED BY LOCAL REGISTRAR DEC 13 1949

REGISTRAR'S SIGNATURE Curtis Williams, M.D.

25. FUNERAL DIRECTOR James L. McCarthy ADDRESS 130 E. Fort Ave

163H ✓

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80791

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80791
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM OLIVER WEAVER

2. DATE OF DEATH Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Marine Hospital
Wyman Pk. Drive & 31st St.

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 432 E. 21st St. 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | W | Single | 5/19/93 1893 | 56 ~~55~~ | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Lamp lighter | | Md. | USA |

13. FATHER'S NAME: William Weaver

14. MOTHER'S MAIDEN NAME: Rebecca ? Smith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW I | 213-12-6017 | Records- US Marine Hospital, | Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial infarction due to arteriosclerotic coronary thrombosis | ½ hr. |
| DUE TO (B) | Arteriosclerotic heart disease | 2 yrs. |
| DUE TO (C) | Arteriosclerosis general | 2 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 6, 1949 *to* Dec. 11, 1949, *that I last saw the deceased alive on* Dec. 11, 1949 *and that death occurred at* 11:25P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D.W. Patrick, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/12/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | Baltimore National | Frederick Road, Balto: Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | George J. Ruth, Inc. | 1735 Harford Avenue |

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680792

BIRTH NO. 680792

1. NAME OF DECEASED (Type or Print): HOWARD F. EVANS.

2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hosp.
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-02
D. STREET ADDRESS (If rural, give location): 7 N. Bentalou St

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: 12/29/1883
9. AGE (In years last birthday): 65 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PAINTER
10B. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Evans
14. MOTHER'S MAIDEN NAME: Margaret Ferguson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown): No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 212-14-8738
17. INFORMANT: Howard F. Evans Jr. ADDRESS: 16 N. Wheeler Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY Ooccur? Inspection Injury

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: John R Evans M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/14/49

24C. NAME OF CEMETERY OR CREMATORY: Western Cem.

24D. LOCATION (City or Town, County) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

FUNERAL DIRECTOR: Joseph B. McWilliams

Gaeth & Strickroth

93D

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80793

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80793
Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Margaret M. Chetelat
2. DATE OF DEATH: Dec 11, 1949

3A. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1501 Hollins St
C. Length of stay in Baltimore: Yrs. 20 Mos. Days 04

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1501 Hollins St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | June 15 1865 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md | |

13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Margaret M. Sewell | 1501 Hollins St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A)
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ____ 19__, *to* ____ 19__, *that I last saw the deceased alive on* 12/11/49 *and that death occurred at* 6.45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | St Joseph's Cem. | Fullerton Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, MD | J. H. C. & B. M. Walters | Pratt & Stricker Sts |

VS 150

131a

G80794

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

144 G80794 Registered No.

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Hiram Cr. Glantz

2. DATE OF DEATH December 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1846 N. Chester St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore B. COUNTY Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) 1846 N. Chester Street 8-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | December 29 1876 | 72 | 11 | 21 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired City Employee | | Baltimore, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Christian Glantz (Germany) | Catherine Glantz (Germany) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs Sophie Glantz | 1846 N. Chester St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arterio Sclerosis | 10 years |
| DUE TO (B) | Hypertension | - - |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Obesity | 15 yrs |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Paraplegia | 6 yrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* ____, 1935, *to* Dec 12, 1949 *that I last saw the deceased alive on* Dec. 11, 1949, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank A. Glantz M. D. | 7 Wendover Road | Dec 12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Dec 15, 1949 | Baltimore Cemetery | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | Albert L. Nulty | 1606 N. Chester St |

VS 150

83D

C80795

C80795

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANTONIO BAHAMONDES

2. DATE OF DEATH: December 11, 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 806 S. Broadway

c. Length of stay in Baltimore: 20 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 806 S. Broadway 2-03

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: May 19, 1888
9. AGE (In years last birthday): 61 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chile ( Valpariso)
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Facudo Bahamondes

14. MOTHER'S MAIDEN NAME: Guaua ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-14-0115

17. INFORMANT 806 S. Broadway ADDRESS: Mr. S.J. Corral-

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: Less than 24 hrs.

DUE TO

(B) Pneumonia — 2 weeks

DUE TO

(C) Bronchial Asthma

Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Dec. 10, 1949 *to* Dec. 10, 1949, *that I last saw the deceased alive on* Dec. 10, 1949, *and that death occurred at* 2 p.m. *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Linden M. D.
23B. ADDRESS: 14 S. Broadway
23C. DATE SIGNED: 12-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/49
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 150

BALTIMORE - 13, MARYLAND 132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80796 ✓ C80796

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 47 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Elizabeth Martha Krauss

2. DATE OF DEATH: Dec. 11, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home 3510 N. Milton Ave
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1217 Scott St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W | Widowed | Feb. 18, 1865 | 84 | 9 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home Duties | | Baltimore | |

13. FATHER'S NAME: Peter Dittmar

14. MOTHER'S MAIDEN NAME: Phillapina Seamon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | None | Bernice Houk | 4101 Hickory Ave. English Council 27 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Hypertensive Cardio Vascular | 3 yrs. |
| DUE TO | Renal Disease | |
| ANTECEDENT CAUSES (B) | Arteriosclerosis | 10 yrs. |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | | |
| (C) | Arthritis | 20 yrs. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 5-16 1946, *to* 12-11 1949, *that I last saw the deceased alive on* 12-10 1949, *and that death occurred at* 3:10 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John P. Ulrich Jr. M. D. | 1227 Wade Blvd | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49. | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Tunstall for Williams M.D. | Frederick A. Cole | 1913 W. Baltimore St. |

VS 150

121a

C80797

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80797

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Solomon Heyman

2. DATE OF DEATH 12-13-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1903 Wheeler Ave

c. Length of stay in Baltimore 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 15-04
d. STREET ADDRESS (If rural, give location) 1903 Wheeler Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | [illegible] | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Hexton | Church | Latv | |

13. FATHER'S NAME Moses

14. MOTHER'S MAIDEN NAME Dora

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Harry Heyman | 3407 Hilton Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(B) Myocarditis

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 10 1949 *to* Dec 13 1949, *that I last saw the deceased alive on* Dec 12 1949, *and that death occurred at* 12 [illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| N. E. Needle M. D. | 2314 W. North Ave | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-13-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Washington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

GM. 134124
C80798

C80798

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — Vernon Fitzberger

2. DATE OF DEATH — 12- 12- 49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — Baltimore City Hospitals, 4940 Eastern Ave.

c. Length of stay in Baltimore — Life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE — MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) — Baltimore
D. STREET ADDRESS (If rural, give location) — 1714 W. North Ave. 15-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | ~~Widower~~ single | Sept. 6-1897 | 52 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Pretzel Baking | MD. | |

13. FATHER'S NAME — Thomas Frederick Fitzberger

14. MOTHER'S MAIDEN NAME — Sophia A. Robinson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| no | | Records B.C.H. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Far advanced bilateral pulmonary tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12- 10- , 1949, *to* 12- 12- , 1949 *that I last saw the deceased alive on* 12- 12- 1949, *and that death occurred at* 5.30 AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rogers M.D. | B.C.H. 4940 Eastern Ave. | 12- 12- 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

13B

C80799 ✓ X C80799

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Stotz — Margaret Elizabeth Stotz

2. DATE OF DEATH 12/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Baltimore General Hosp.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lochearn
D. STREET ADDRESS (If rural, give location): 3721 Patterson Ave.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 1, 1900
9. AGE (In years last birthday): 49 yrs (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John B. Stotz
14. MOTHER'S MAIDEN NAME: Helen Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Christine DeVilbiss, ADDRESS: 2302 Birch Ave. Larchmont

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage — DUE TO
ANTECEDENT CAUSES
(B) HCVD — DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 31 days

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 5th, 1949, *to* Dec. 12th, 1949, *that I last saw the deceased alive on* Dec. 12th, 1949, *and that death occurred at* 11:57 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Katharine V. Kemp, M.D.
23B. ADDRESS: West Balto. Gen. Hosp.
23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 15, 1949
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR: [redacted] Baltimore, Md.
25. FUNERAL DIRECTOR: C. Willis Lemoreaux
ADDRESS: 4510 Liberty Heights Ave.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93D

C80800

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 59

C80800 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Arabelle Bobb Johnson

2. DATE OF DEATH: Dec 10 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-CY
D. STREET ADDRESS (If rural, give location): 811- S. Greene St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 811- S. Greene St.

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 67 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Kustin
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Polly Johnson — ADDRESS: Wash. D.C.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 1 wk |
| DUE TO (B) | Chr. Glomerular Nephritis | undet |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Decubitus Ulcer. | undet. |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 15 1949 *to* Dec 10, 1949, *that I last saw the deceased alive on* Dec 8, 1949, *and that death occurred at* 2.50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Garland Pinnell M.D.
23B. ADDRESS: 912 W. Franklin St
23C. DATE SIGNED: 12-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemet.
24D. LOCATION (City, town, or county) (State): Cedar Hill Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: [illegible] Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: A. Halstead — ADDRESS: 918 Druid Hill Ave

VS 150

1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied as correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80801

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C80801 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard E. Dannenfelser

2. DATE OF DEATH: DEC 10-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — BALTC - MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CITY HOSPITAL

C. Length of stay in Baltimore: LIFE (Yrs. / Mon. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. Back River
D. STREET ADDRESS (If rural, give location): SANDY POINT
63 E RIVERSIDE AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | FEB 29 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED | POLICE BALTO CITY | BALTO | U. S. A |

13. FATHER'S NAME: MARTIN DANNENFELSER

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT |
|---|---|---|---|
| YES | WAR I | NONE | MARTHA A. DANNENFELSER 63 E RIVERSIDE AVE. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Lost + Dog

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl L Rogers M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 11 Dec 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC 14 1949 | MT CARMEL CEMETERY | O'DONNELL ST. MD |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13

REGISTRAR'S SIGNATURE: Lucy Covington for Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Duffel Bro. 1800 E LOMBARD ST

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 151

94a

C80802

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80802 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EVA Mrs. MARY SCOTT

2. DATE OF DEATH: 12-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5705 BELAIR RD.
c. Length of stay in Baltimore: LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE.
D. STREET ADDRESS (If rural, give location): 5705 BELAIR RD.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | DIVORCED | MARCH 25 1916 | 34 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CLERK. | TRU-BLUE LAUNDRY. | BALTIMORE | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HARRY J. MURPHY. | EVA SCHELLENBERGER. |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | 214-03-7874 | JULIA ELLIS | 5705 BELAIR RD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Hemorrhage | 1 day |
| DUE TO (B) | For advanced Tuberculosis (Pulmonary) | 3 years |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 20, 1949, to Dec. 11, 1949, *that I last saw the deceased alive on* Dec. 11, 1949, *and that death occurred at* 3:45 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Michael J. Daunch M. D. | 4636 Belair Road | 12/11/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC 14 1949 | PARKWOOD CEM | TAYLOR AVE MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | Duffel Bro. | 1118 BELAIR RD |

VS 150

13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80803

BIRTH NO. 134121

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E916.0

Registered No.

1. NAME OF DECEASED (Type or Print): Virginia, Lee Ulbig.

2. DATE OF DEATH: Dec. 12-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Box. 247 Miles RD. Z 21- County

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single. | Aug. 7, 1935 | 14 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland. | |

13. FATHER'S NAME: Herman, A. Ulbig.

14. MOTHER'S MAIDEN NAME: Mary, Baker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Records B.C.H. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Edema.

DUE TO

(B) Burns of body and Respiratory Tract.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
Dr. John R. Davis
per: A. A. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Fire in home | Box 247 Miles RD. Z 21 County |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 12-10-49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fire in home |

22. *I hereby certify that I attended the deceased from* 12-10- 19 49 *to* 12-11-49, 19___, *that I last saw the deceased alive on* 12-11-49, 19___, *and that death occurred at* 7.35 AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. L. Cooper M. D. | 4940 Eastern Ave | 12-11-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 14-49 | Balto. Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 13 1949 | Courtney Williams, M.D. | John A. Hillen 2334 Jefferson St |

VS 150

TO BE APPROVED BY THE MEDICAL EXAMINER

180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80804 ✓ 57 v.1 C80804

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stella O. Lee

2. DATE OF DEATH: 12-11-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: ~~Yrs.~~ Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 1422 Linden Avenue 14-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 4 - - 1871
9. AGE (In years last birthday): 78
If Under 1 Year: Months: Days
If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Harford Co., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John T. Truett
14. MOTHER'S MAIDEN NAME: Virginia A. Conway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Husband — ADDRESS: Fish Pound Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gastro intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: one day?
DUE TO
(B) Diverticulosis of sigmoid colon — Adenocarcinoma sigmoid colon — 5 yrs.
DUE TO
(C) lites sigmoid colon. No malignancy.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Coronary occlusion & myocardial infarction ? A.H.D. Hardened

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-7-, 1949 *to* 12-11, 1949 *that I last saw the deceased alive on* 12-11, 1949, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Louisa Candler M. Dr.
23B. ADDRESS: Maryland General Hospital
23C. DATE SIGNED: 12-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/49
24C. NAME OF CEMETERY OR CREMATORY: Highland Presbyterian
24D. LOCATION (City, town, or county) (State): Harford Co., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. D. Meaks and Son
ADDRESS: 1 N. Calvert St.

VS 150

123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80805 HARRIS ✓ Harris C80805

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTHA HARRIS

2. DATE OF DEATH: 12/9/49

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 711 W. FRANKLIN ST

c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO. 17-03
D. STREET ADDRESS (If rural, give location): 711 W FRANKLIN ST.

5. SEX: FEMALE
6. COLOR OR RACE: COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MAR 25, 1883
9. AGE (In years last birthday): 66 — Under 1 Year: Months 8, Days 14; Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): SNOW HILL MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Hearn.
14. MOTHER'S MAIDEN NAME: ANNIE JOHNSON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: GERTRUDE JACKSON ADDRESS: 711 W FRANKLIN

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CARDIO VASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 2 YRS.
DUE TO
(B) BROKEN COMPENSATION — 6 MOS
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE 15, 1930 19 48, *to* DEC 7, 19 49 *that I last saw the deceased alive on* Nov. 23, 19 49, *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Frey M. D.
23B. ADDRESS: 1928 Penna Ave
23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-13-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Limited for Baltimore, Md.
25. FUNERAL DIRECTOR: Mrs Kate R. Wellons
ADDRESS: 3221 Edmondson

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80855

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44 ✓ Registered No. G80806

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Harry Tyler**

2. DATE OF DEATH **12-11-49**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.**

C. Length of stay in Baltimore **life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **528 Vincent St. Zone 23** 19-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| **Male** | **Negro** | **Married** | **Aug. 15, 1907** | **42** | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | **Maryland** | |

13. FATHER'S NAME **Unknown**

14. MOTHER'S MAIDEN NAME **Dead**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS **Baltimore City Hospitals Records--4940 Eastern Ave.**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) **Uremia and Hypertensive Heart Disease**

DUE TO

(B) **Nephrosclerosis**

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **11-30-** 19**49**, *to* **12-11-** 19**49**, *that I last saw the deceased alive on* **12-11-** 19**49**, *and that death occurred at* **10:20AM** *from the causes and on the date stated above.*

23A. SIGNATURE **R. L. Rozen** M. D.

23B. ADDRESS **B.C.H.--4940 Eastern Ave.**

23C. DATE SIGNED **12-11-49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **12-15-1949**

24C. NAME OF CEMETERY OR CREMATORY **Arbutus Memorial**

24D. LOCATION (City, town, or county) **Arbutus** (State) **Md.**

DATE RECEIVED BY LOCAL REGISTRAR **DEC 13 1949**

REGISTRAR'S SIGNATURE **Tuttington Williams, M.D.**

25. FUNERAL DIRECTOR **Mrs Kate R Williams & Son**

ADDRESS **22 N**

VS 150

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80807 CERTIFICATE CORRECTED 1/9/50 ✓ 49 D G80807

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mathilda Libby (GIVEN) Harris

2. DATE OF DEATH 12-10-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hosp.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 13-03
D. STREET ADDRESS (If rural, give location) 2602 Woodbrook Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Married | 12-15-1923 | 26 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shipping Clerk | | Philadelphia Pa. | U.S.A. |

13. FATHER'S NAME William Harris

14. MOTHER'S MAIDEN NAME Ester Williams

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Gladys Harris | 1007 N. Payson St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Ruth Boyer M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED 11 Dec 49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 12-14-1949 | N.W. Auburn Cem. | Balto. | Md. |

DATE RECEIVED BY LOCAL REGISTRAR DEC 16 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Mrs Katie R. Williams | ADDRESS 322 Schroeder St

VS 151

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80808

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

763 Registered No. G80808

BIRTH NO. 49-25488

1. NAME OF DECEASED (Type or Print): Vivian Blanford

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 35 W. Cross St. 23-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | | 11/27/49 | | | 14 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas Blanford
14. MOTHER'S MAIDEN NAME: Isadora ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Isadora Blanford ADDRESS: 35 W Cross St

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Septicemia with interstitial pneumonitis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Aspiration of gastric content | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec 12 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | Mt Calvary | A. A. Co., Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: D. L. Brown & Son ADDRESS: 108 W. Montgomery St

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

114E

C80809

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80809

Registered No.

1. NAME OF DECEASED (Type or Print): THOMAS POWELL

2. DATE OF DEATH: 12-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1002 E. EAGER ST.

c. Length of stay in Baltimore: 8 ✓ Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1002 E. EAGER ST. 10-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C. | MARRIED | 7-23-1889 | 60 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LABORER | CONSTRUCTION CO. | N. C. | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | KATE POWELL | 1002 E. EAGER |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 140 hrs.

DUE TO

(B) Hypertensive Cardio-Renal disease — 4 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Dec 7, 1949 *to* Dec 10, 1949 *that I last saw the deceased alive on* Dec 10, 1949 *and that death occurred at* 7:15A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis B. Lake M. D. | 1501 E. Eager St. | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| REMOVAL | 12-15-49 | | HALIFAX N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, MD | Joseph D. Locks, Jr. | 1304 N. Central Ave |

VS 150

1310

Please write plainly with unfading ink. Every item should be answered. Information should be complete and correct as of the time of death. Physicians: please write the causes of death clearly and legibly. Especially important.

C80810

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80810

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY V. REITER

2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3237 Elmora Avenue

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: June 20, 1870
9. AGE (In years last birthday): 79 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John Hagan
14. MOTHER'S MAIDEN NAME: Mary E. Duncan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: none
17. INFORMANT: Miss Edith M. Bell — ADDRESS: 3203 Elmora Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Adeno-carcinoma of ovary with metastases to peritoneal cavity and intestinal obstruction — Interval between onset and death: 12 hrs.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: October 17, 1949
19B. MAJOR FINDINGS OF OPERATION: Adeno-carcinoma of left ovary
20 AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Chester J. Lubinski, M.D.
per: B S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-16-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

VS 151

49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

80811

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80811

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD F. BARNETT

2. DATE OF DEATH: Dec. 11, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1915 Division Street

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1915 Division Street 17-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 1 day: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widower | March 10, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Insurance solicitor | Life insurance | Baltimore, Md. | |

13. FATHER'S NAME: Zecharia Barnett

14. MOTHER'S MAIDEN NAME: Lillie P. Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 220-09-2669

17. INFORMANT: Mrs. Hilda Clark ADDRESS: 1915 Division St.

## MEDICAL CERTIFICATION

19. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 9
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility —

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Oct 7 1949 to Dec 11 1949 that I last saw the deceased alive Dec 11, 1949, and that death occurred at 11:30 m. from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. B. Hughes M. D. | 1413 Druid Hill Ave | Dec. 13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 14, 1949 | Arbutus Memorial Pk. | Baltimore Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

PLEASE WRITE PLAINLY IN INK. WITH UNFADING BLACK. EVERY ITEM MUST BE ANSWERED. IF UNKNOWN, STATE SO. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1310

MS—134088

G80812

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80812

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles Victor DeCasseres

2. DATE OF DEATH 12-11-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Anne Arundel County 14-0-2
D. STREET ADDRESS (If rural, give location) 559 Preestman St. Crownsville State Hospital

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Divorced | Nov. 1, 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Physician | M.D. | Maryland | |

13. FATHER'S NAME: Eustace DeCasseres

14. MOTHER'S MAIDEN NAME: Adele Waters

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records—4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bilateral Pulmonary Tuberculosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-10-49 | Operation—Pre-frontal lobotomy | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12-9- , 1949, *to* 12-11- , 1949, *that I last saw the deceased alive on* 12-11- , 1949, *and that death occurred at* 9:00P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. S. Cogan M. D. | B.C.H.—4940 Eastern Ave. | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 15, 1949 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | Holland Funeral Home 1631 Druid Hill Ave. |

VS 150

130

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80813

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

J-17

Registered No. G80813

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph J. Owsik

2. DATE OF DEATH 12-11-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3726 6th St #25

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | 3-7-09 | 40 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter

10B. KIND OF BUSINESS OR INDUSTRY Ship Repair

11. BIRTHPLACE (State or foreign country) Balto. Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Zygmunt Owsik

14. MOTHER'S MAIDEN NAME Walerya Maholski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-03-7515

17. INFORMANT Rose Owsik ADDRESS 3726-6th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Hepato-Renal Failure — Interval between onset and death: 12 hrs.

DUE TO

(B) Abdominal Exploration & Appendectomy — 7 days.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION 12-4-49

19B. MAJOR FINDINGS OF OPERATION Post Operative Abdominal Adhesions.

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-27-, 1949 *to* 12-11, 1949 *that I last saw the deceased alive on* 12-11, 1949, *and that death occurred at* 1 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE Robert B. McFadden

23B. ADDRESS St Agnes Hospital

23C. DATE SIGNED 12-11-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Dec. 15-1949

24C. NAME OF CEMETERY OR CREMATORY Holy Cross

24D. LOCATION (City, town, or county) (State) Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR DEC 13 1949

REGISTRAR'S SIGNATURE Emily Taylor Williams, M.D.

25. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2007 Eastern Ave

VS 150

129

G80814 E900.0 G80814

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No. B-204-7

1. NAME OF DECEASED (Type or Print): BENJAMIN WORSHAM
2. DATE OF DEATH: December 11, 1949

3. PLACE OF DEATH: Baltimore City, Maryland
a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital
c. Length of stay in Baltimore (Yrs. Mos. Days):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 618 S. Bouldin Street 26-11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 7/6/1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | Balto. City | Md. | U.S.A. |

13. FATHER'S NAME: George Worsham
14. MOTHER'S MAIDEN NAME: Anna Hiltz

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No — | ? | Loretta Worsham | same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fractured skull
DUE TO
(B) Intracranial hemorrhage
Fractured ribs
DUE TO
(C) Coronary atherosclerosis
Healed Myocardial infarction

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] ~~CAUSE OF~~ DEATH
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 618 S. Bouldin Street
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 11, 1949 P.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell down the stairs inside

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George S. Mensill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 12-12-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | Mt. Carmel | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Selby & Zeiler Inc.
ADDRESS: Balto. Md.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

186a

G80815

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1794

G80815

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Samuel Ward

2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 148 W. HAMBURG St

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto Md
B. COUNTY: 23-01
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 148 W Hamburg Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | — | | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Retired | Balto Md | |

13. FATHER'S NAME: James Ward

14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Annie William — ADDRESS: 148 W Hamburg St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) General Senile Deterioration — Unknown

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 2, 1949 *to* Dec 11, 1949, *that I last saw the deceased alive on* Dec 10, 1949 *and that death occurred at* 4 PM m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John W Haines M. D. | 507 W. Hamburg St | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | ISAIAH L BROWNSON | 108 W Monty Omaryll |

DEC 13 1949

162 B

correct age is especially important. Physician: please write the cause of death clearly and legibly.

C80816

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80816

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Nicholas L. Schneider

2. DATE OF DEATH 12-11-49

3. PLACE OF DEATH: a. Baltimore City, Maryland Baltimore

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 616 So. Ellwood Ave

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 616 So. Ellwood Ave 1-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 8-15-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Manger | Grocery Store | Maryland | |

13. FATHER'S NAME Nicholas L. Schneider

14. MOTHER'S MAIDEN NAME Theresa Hirsch

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs Myrtle Schneider | 616 So. Ellwood Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension C.V. Disease — INTERVAL BETWEEN ONSET AND DEATH: Oct 1, 1948

DUE TO

(B) Chronic nephritis — June 2 1949

DUE TO

(C) Acute Coronary Occlusion — Dec 11/49

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | None | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | None | None |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | WHILE AT WORK ☐ WHILE AT WORK ☐ | None |

22. *I hereby certify that I attended the deceased from* Oct 1 1948 *to* Dec 11 1949 *that I last saw the deceased alive on* Dec 12 1949 *and that death occurred at* 12:40 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. Schenuck M.D. | 842 S Exeter | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-15-49 | Oaklawn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams M.D. | John A. Moran | 3000 E. Balto. St. |

VS 150

931

Please write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

G80817 — BALTIMORE CITY HEALTH DEPARTMENT — G80817

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO. 49-26209

1. NAME OF DECEASED (Type or Print): Baby Boy Sparrow

2. DATE OF DEATH: DEC 4 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4 N. Carlton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 12-4-49 | 0 | | 10 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Robert Thomas

14. MOTHER'S MAIDEN NAME: Constance Sparrows

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

(B) Atelectasis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* ____ 19__, *to* 12-4, 1949, *that I last saw the deceased alive on* 12-4, 1949 *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison Clark Spencer M. D. | JOHNS HOPKINS HOSPITAL | 12/6/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Holy Redeemer | |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS

VS 150

159

PLEASE WRITE PLAINLY IN INK. ANSWER ALL QUESTIONS. Every item of information should be given if possible. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G80818 Jr. 134010

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

776 Registered No. G80818

BIRTH NO. 49-26821

1. NAME OF DECEASED (Type or Print): Baby Boy Robertson- Lottie

2. DATE OF DEATH: 12-7-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: Yrs. 1 day Mos. s. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1035 Wolfe St. 7-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | Single | Dec. 6, 1949 | | | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Waverly Robertson

14. MOTHER'S MAIDEN NAME: Lottie Watson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | B. C. H. Records, 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Prematurity | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Dec. 6, 1949, *to* Dec. 7, 1949 *that I last saw the deceased alive on* Dec. 7, 1949, *and that death occurred at* 1.35A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Rogers M. D. | 4940 Eastern Ave. | Dec. 9, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremated | Dec. 9, 1949 | B. C. H. Crematory | 4940 Eastern Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Timothy for Williams, M.D. | | |

VS 150

159

Please write plainly in ink. Physicians: please write the cause of death clearly and legibly. This certificate is especially important.

—133972
G80819

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 r 5 4

Registered No. G80819

BIRTH NO. 49-26239

1. NAME OF DECEASED (Type or Print) Baby Girl Southerland

2. DATE OF DEATH 12-8-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Yrs. Mos. Days — life

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1701 Reisterstown Road 14-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Nov. 28, 1949 | | 10 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: James Southerland

14. MOTHER'S MAIDEN NAME: Doris Southerland

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT'S ADDRESS |
|---|---|---|---|
| | | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Mongolism-Congenital absence of the Choanae | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12-5- , 1949, *to* 12-8- , 1949, *that I last saw the deceased alive on* 12-8- , 1949 *and that death occurred at* 1:00P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. L. Rogers M. D. | B.C.H.--4940 Eastern Ave. | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremated | 12-10-49 | Baltimore City Hospitals Crematory | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | |

VS 150

84a

PLEASE WRITE PLAINLY. Do not use ditto marks. Be sure to answer all questions. Be sure that the cause of death is stated correctly and legibly. Physicians: please write the cause of death clearly and legibly.

C80820

# CERTIFICATE CORRECTED 12-20-49

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. C80820

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE W. TYLER

2. DATE OF DEATH: 12/10/49

3. PLACE OF DEATH: Baltimore City, Maryland — Baltimore City

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 426 N. Carey St

b. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 426 N. Carey St. 1 9 0 1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | C | Widowed | 3/12/1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mail Handler | U.S.Post Office | Baltimore, Md | U.S.A. |

13. FATHER'S NAME: Wm. George Tyler

14. MOTHER'S MAIDEN NAME: Nannie

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| W.W.#1 | W.W.#1 | | HERBERT O. Tyler(S) | 426 N.Carey St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: a few Mins

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardiovascular disease — DUE TO — 1947?

(C) Hypertension — 1947?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

None

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 5, 1947 to Dec, 1949, *that I last saw the deceased alive on* 12/3, 1949, *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Walter Sherwington M.D. | 201 N Carey St | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/14/49 | Arbutus Memorial | Balto County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | Chas Harper | 512 Cumberland Av |

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80821

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.0 G80821

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Margaret Young
2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

9. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General German Aged Home
D. STREET ADDRESS (If rural, give location): 22 S. Athol Ave 28-04

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: Female | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH: Feb. 14, 1866 | 9. AGE (In years last birthday): 83 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Adam Heinreich | 14. MOTHER'S MAIDEN NAME: Catherine Schaller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. J. Dec. Young | ADDRESS: 22 S. Athol Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Edema | Unknown. |
| DUE TO (B) | Cardiac Arterial Sclerosis | Unknown. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | (Broncho Pneumonia, Pelvic Abscess.) | Unknown. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 20/49. , 19 , *to* Dec. 11/49? , *that I last saw the deceased alive on* Dec. 6/49? , *and that death occurred at* 2.40PM. *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Woods Shields M.D. | 23B. ADDRESS: 933 Hanover St. | 23C. DATE SIGNED: Dec. 12/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 12/14/49 | 24C. NAME OF CEMETERY OR CREMATORY: Baltimore | 24D. LOCATION (City, town, or county) (State): North Ave. Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949 | REGISTRAR'S SIGNATURE: [illegible] Williams, M.D. | 25. FUNERAL DIRECTOR: Harry H. Wintzfe. | ADDRESS: 4101 Edmondson Ave

VS 150

139a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80822

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Reg. No. 1 G80822

DEATH NO. G80822

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN E. BOHLMAN

2. DATE OF DEATH: DEC. 11, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 20-07
D. STREET ADDRESS (If rural, give location): 2745 W. FAIRMOUNT AVE

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2745 W. FAIRMOUNT AVE

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | APRIL 28 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| PIPE FITTER | B & O. R.R. | MARYLAND | |

13. FATHER'S NAME: JOHN D BOHLMAN

14. MOTHER'S MAIDEN NAME: LAURA HUBBARD

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | MRS MARIE BOHLMAN | 2745 W FAIRMOUNT |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Occlusion | 10 minutes |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Angina Pectoris | 14 months |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* OCT. 14th, 1946, to DEC. 11th, 1949, *that I last saw the deceased alive on* Dec. 10th, 1949, *and that death occurred at* 12:10 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gilbert E. Bohlman M. D. | 2517 W. Baltimore St. | Dec. 12th, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Dec 15'49 | MT OLIVET | BALTIMORE, MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | Harry A Wiltse - 4101 Edmondson Ave |

94a

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G80823 ✓ G80823

BALTIMORE CITY HEALTH DEPARTMENT 1949 Registered No.

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Patricia E. McDermott

2. DATE OF DEATH: Dec. 11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 754 Linnard St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 754 Linnard St. 16 08

5. SEX: Female
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan. 8, 1942
9. AGE (In years last birthday): 7 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Frank McDermott
14. MOTHER'S MAIDEN NAME: Hilda McConnell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frank McDermott, 754 Linnard St. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intra-medullary astrocytoma of the spinal cord.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: 19 Oct 1949
19B. MAJOR FINDINGS OF OPERATION: Spinal cord tumor
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 Oct, 1949, *to* 11 Dec, 1949, *that I last saw the deceased alive on* 10 Dec 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: Emil N. Henning Jr. M.D.
23B. ADDRESS: 601 Winans Way
23C. DATE SIGNED: 12 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Harry A. Mintzer (ADDRESS): 401 Edmondson Ave.

VS 150

54a

Physicians: please write the cause of death clearly and legibly. Important. correct age is especially

G80824

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. G80824 Registered No.

1. NAME OF DECEASED (Type or Print): GERNIE B. FIREBAUGH

2. DATE OF DEATH: DEC. 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 53 N. MONASTERY AVE
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 53 N. MONASTERY AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | AUG. 29 1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CHAUFFEUR | BALTO. TRANSIT CO. | VIRGINIA | |

13. FATHER'S NAME: EMMETT FIREBAUGH

14. MOTHER'S MAIDEN NAME: MARY BARE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 213-40-0732 | WIFE MRS CHARLOTTE FIREBAUGH | MONASTERY AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
(B) Coronary Thrombosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* DEC. 11, 1949, *to* DEC 11, 1949, *that I last saw the deceased alive on* DEC. 11, 1949, *and that death occurred at* 1:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard Yaffe M. D. | 3101 W Baltimore St | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC 14 1949 | LOUDON PARK | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | [illegible] | Harry A Wright | 4101 Edmondson Ave |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly

94a

G80825

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 120 1 Registered No. G80825

1. NAME OF DECEASED (Type or Print) Frederick Henry Storm

2. DATE OF DEATH 12/12/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20 01
D. STREET ADDRESS (If rural, give location) 410 N. MONROE ST

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 410 N. MONROE ST

c. Length of stay in Baltimore Yrs. Mos. Days

5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH SEPT. 13 1869
9. AGE (In years last birthday) 80 If under 1 Year: Months Days If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED
10B. KIND OF BUSINESS OR INDUSTRY SALESMAN
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME FREDERICK H STORM
14. MOTHER'S MAIDEN NAME LOUISE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT MRS VERNON C STORM ADDRESS 410 N. MONROE ST

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Myocardial infarction | 15 hours |
| | DUE TO | Coronary occlusion | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Arteriosclerosis | 15 years |
| | DUE TO | | |
| | (C) | Myocardial insufficiency | 40 days |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1949, to December 12 1949 *that I last saw the deceased alive on* Dec 9, 1949, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE Charles Storm M. D.
23B. ADDRESS 6 E. Read St.
23C. DATE SIGNED 12/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE DEC. 14 '49
24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK
24D. LOCATION (City, town, or county) (State) BALTIMORE MD

DATE RECEIVED BY LOCAL REGISTRAR DEC 13 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR HARRY M CLARKE
ADDRESS 401 GARRISON

VS 150

94a

Please write clearly and legibly. Physicians: please write the causes of death clearly and correct age is especially important.

C80826

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80826

BIRTH NO. 79-1891

1. NAME OF DECEASED (Type or Print): Nancy M. Lansinger

2. DATE OF DEATH: Dec. 10/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

4. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4004 Colbourne Rd.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Sept. 18/49

9. AGE (In years last birthday): If Under 1 Year: Months 2, Days 22; If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Thomas Lansinger

14. MOTHER'S MAIDEN NAME: Regina Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT / ADDRESS: Thomas Lansinger, 4004 Colbourne Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Interstitial pneumonia — DUE TO

ANTECEDENT CAUSES

(B) — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Earl L. Royer, M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 11 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/14/49

24C. NAME OF CEMETERY OR CREMATORY: Parkwood

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 13 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Harry A. Pinkett — ADDRESS: 4101 Edmondson Ave.

VS 151

114E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80827 — BALTIMORE CITY HEALTH DEPARTMENT — C80827

# CERTIFICATE OF DEATH

BIRTH NO. 49-29596 — Registered No.

1. NAME OF DECEASED (Type or Print): BABY BOY BOSLEY — 2. DATE OF DEATH: 12-12-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital, Redwood and Green Sts

c. Length of stay in Baltimore: 3 hrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md. — b. COUNTY: Baltimore County
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Reisterstown — Rural
d. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | | 12-11-49 | | | 3 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md | U.S.A. |

13. FATHER'S NAME: Milford H Bosley

14. MOTHER'S MAIDEN NAME: Dorothy E Tracey

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | | — |

17. INFORMANT: Milford H Bosley — ADDRESS: Reisterstown Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia neonatorum — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

DUE TO

(B) Shock

DUE TO

(C) Prematurity

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9:25 AM 12-12-49 *to* 12:5 PM 12-12 *19*49, *that I last saw the deceased alive on* 12-12, *19*49, *and that death occurred at* 12:5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James Lathrop, M.D. | Univ Hospital, Balt. Md | 12-2-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-13-49 | Mt Zion | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 13 1949 | Huntington Williams, M.D. | Edward C Tipton | Hampstead Md |

VS 150

159

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

31482

G80828

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

G80828

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Henrietta Knight

2. DATE OF DEATH: Dec. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Chapsico - wd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: St. Marys
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Compton
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-6-1909
9. AGE (In years last birthday): 40
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry E. Fritch
14. MOTHER'S MAIDEN NAME: Nellie Young

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardiovascular
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Cerebrovascular accident
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH
(A) Uncertain

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-22-, 1949 *to* 12-13-, 1949, *that I last saw the deceased alive on* 12-13-, 1949, *and that death occurred at* 7 45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert M Vannier M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 12-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/16/49
24C. NAME OF CEMETERY OR CREMATORY: ST. FRANCIS
24D. LOCATION (City, town, or county) (State): COMPTON, ST. MARYS MD

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: JOS. L. MATTINGLEY ADDRESS: LEONARDTOWN MD

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80829

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 43

C80829 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Castel, FRANK J.

2. DATE OF DEATH: December 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1912 Cecil Avenue 9-08

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 7/5/1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chef
10B. KIND OF BUSINESS OR INDUSTRY: Cooking

11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (Unknown) Castel

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-18-0460

17. INFORMANT: Lee. J. Castel ADDRESS: 920 Woodlynn Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease with cardiac decompensation

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 11, 1949 *to* Dec. 12, 1949 *that I last saw the deceased alive on* Dec. 12, 1949, *and that death occurred at* 7:35 AM., *from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Dworinska M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: Dec. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/14/49
24C. NAME OF CEMETERY or CREMATORY: Bur. — St. Peters
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Wm. Cook Inc. ADDRESS: 1217 St. Paul St

VS 150

937

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80830

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

53

G80830
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DORCAS E. PILKERTON

2. DATE OF DEATH: Dec. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2681 Eagle St.

c. Length of stay in Baltimore: Yrs. Mon. Days: 20 0 5

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2681 Eagle St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | Nov. 11, 1870 | 79 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Maryland | |

13. FATHER'S NAME: William Cochran

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs Charles Collins | 2681 Eagle St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Stomach | 8 mo |
| DUE TO (B) | Chronic Fibroid Pulmonary Tuberculosis | 6 yrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 12, 1949 *to* Dec 12, 1949, *that I last saw the deceased alive on* Dec 11 1949, *and that death occurred at* 4:30a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. F. A. Stevens M. D. | 2878 Stanford Rd | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Holy Cross | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 14 1949 | Entries for Williams, M.D. | William Cook, Inc. |

46E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80831

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80831

1. NAME OF DECEASED (Type or Print): HOWARD W MERCER Sr.

2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 822 N. Brice Street 16-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 8/8/1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stone Mason | Building | Balto. Md. | |

13. FATHER'S NAME: Frederick Mercer

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Howard W. Mercer Jr. | 1328 Mobile Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Coronary artery disease | |
| | DUE TO | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Mt. Olivet | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Deputy for Williams, Reg. | Wm Cook Inc. | 127 St. Paul St. |

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

C80832

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

C80832

Registered No.

1. NAME OF DECEASED (Type or Print): Bessie F. Bunee

2. DATE OF DEATH: Dec. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2704 Mathews St. 9 04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | March 10, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Ø | Maryland | U. S. A. |

13. FATHER'S NAME: Henry Craig

14. MOTHER'S MAIDEN NAME: Margaret Black

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Union Memorial (hospital records | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 2 days.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* December 11, 1949, *to* December 13, 1949, *that I last saw the deceased alive on* December 12, 1949, *and that death occurred at* 5:15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A. Ramson M. D. | Union Memorial Hospital | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Druid Ridge | Pikesville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Huntington Williams, M.D. | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80833

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331

G80833
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rosina Brown

2. DATE OF DEATH: December 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 76-44 7 S. Kresson St. 7 S. Kresson St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Widowed | 11/30/1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Hwfe. | At Home | Baltimore | |

13. FATHER'S NAME: Peter A. Franz

14. MOTHER'S MAIDEN NAME: Sarah Turner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Essential Hypertension

DUE TO

(C) Generalized arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 10, 1949 *to* Dec. 12, 1949 *that I last saw the deceased alive on* Dec. 12, 1949, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. M. Kaan M. D.

23B. ADDRESS: 1400 N. Caroline St.

23C. DATE SIGNED: Dec. 12, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/16/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: Wm Cook Inc. 1217 St. Paul St

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80834 ✓ G80834

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 175 Registered No.

1. NAME OF DECEASED (Type or Print): REVA BERTHA WOODEN

2. DATE OF DEATH: 10 DEC. 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland ST. JOSEPHS HOSP.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPHS HOSP.

C. Length of stay in Baltimore: 20 YRS. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 23-07
D. STREET ADDRESS (If rural, give location): 1614 MARSHALL ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | 14 DEC. 1902 | 46 | 11 / 26 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | | W. VA. | U.S. |

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Howard C. Wooden | 1614 Marshall St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) INTESTINAL OBSTRUCTION — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 3 WKS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) METASTOTIC CARCINOMA — DUE TO

(C) CARCINOMA, OVARY

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 29 Nov 1949 *to* 10 Dec 1949 *that I last saw the deceased alive on* 10 Dec 1949 *and that death occurred at* 11:50 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James A. O'Hare M. D. | 24 Saint Paul Place | Dec. 10, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 14, 1949 | Funeral Cemetery | Funeral Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 26. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Huntington Williams M.D. | John F. Denny Inc | 715 Eight St. |

VS 150

49a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80835

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17° C80835 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNIE SCHEVKER

2. DATE OF DEATH 12-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 3706 Hortonia Road

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-12

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Mount Howe

c. Length of stay in Baltimore 60 Yrs. ~~Mos.~~ ~~Days~~

D. STREET ADDRESS (If rural, give location) 3738 Tocwanda Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | | 73 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jacob

14. MOTHER'S MAIDEN NAME Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Jane Scheiker - 2309 Enoka Ave ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast with pulmonary metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic heart disease with hypertension — 15 yrs

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1934 to 12/13, 1949, that I last saw the deceased alive on 12/13, 1949, and that death occurred at 12-9 m., from the causes and on the date stated above.

23A. SIGNATURE Martin B Kurz M.D. M. D.

23B. ADDRESS 2320 Eutaw Pl

23C. DATE SIGNED 12/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12-14-49

24C. NAME OF CEMETERY OR CREMATORY Rosedale

24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 14 1949

REGISTRAR'S SIGNATURE Hunter for Williams, M.D.

25. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl

VS 150

50

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

C80836

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. C80836

1. NAME OF DECEASED (Type or Print): Tenroff, Anna (Silk)

2. DATE OF DEATH: 12/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: Yrs. 3 Mos. 0 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md.
D. STREET ADDRESS (If rural, give location): 1108 E. Lombard

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

13. FATHER'S NAME: Mankel

14. MOTHER'S MAIDEN NAME: Leah

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Name, address and relationship, if any) |
|---|---|---|---|
| | | | Henry Tenroff 1108 E Lombard St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
A. ? Pulmonary Infarct
DUE TO
ANTECEDENT CAUSES
B. ? Coronary Thrombosis
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
C.
D.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give street location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12/7 19 49 to 12/13 19 49, that I last saw the deceased alive on 12/13 19 49 and that death occurred at 10:5 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| N. Thal M.D. | Sinai Hosp. | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12-14-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | [illegible] for [illegible], M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80837 ✓ C80837

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 443

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA SHOCKET

2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7015 Fieldcrest Road

c. Length of stay in Baltimore: 38 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 7015 Fieldcrest Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | If Under 1 Day: Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | | 66 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia | |

13. FATHER'S NAME: Jacob

14. MOTHER'S MAIDEN NAME: Dora

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Jack Shocket | 3329 Alto Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure

DUE TO

(B) Hypert. Cardio vascular disease decompensation

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1947 to Dec 14, 1949 *that I last saw the deceased alive on* Dec 14, 1949 *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| KURT [illegible] M. D. | 303 N. Caroline St. | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-16-49 | Hebrew Herzug Ave | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | [illegible] | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

937

C80838 ✓ C80838

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4700

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MICHAEL MILLER

2. DATE OF DEATH: 12/13/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: 47 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 ✓
D STREET ADDRESS (If rural, give location): 4207 Maine Ave

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Jan 25/1881
9. AGE (In years last birthday): 62 (If under 1 year: Months; Days. If under 24 hours: Hours; Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fur & Dress Business- Own
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Poland
12. CITIZEN OF WHAT COUNTRY? Usa.

13. FATHER'S NAME: David Miller
14. MOTHER'S MAIDEN NAME: Ida ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT ADDRESS: Mrs. Ida Miller- 4207 Maine Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarct
DUE TO
ANTECEDENT CAUSES
(B) Coronary occlusion
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C) ASHD

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Tbc of lungs & kidneys

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/10, 1949 to 12/13, 1949 that I last saw the deceased alive on 12/12, 1949, and that death occurred at 7:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE: William Lukanow M.D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 12/13/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-14-49
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: Emerson for Williams, M.D.
25. FUNERAL DIRECTOR (ADDRESS): Sol Levinson & Bros. 1124-26 N. North Avenue

VS 150

1310

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80839

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

C80839

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): RODNEY CHAMBERS

2. DATE OF DEATH: Dec. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 230 S. Conkling St.,
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 32 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 230 S. Conkling St., 26-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 3, 1913 | 36 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Welder | Air lanes | NorthEast, Md. | |

13. FATHER'S NAME: Phineas Chambers

14. MOTHER'S MAIDEN NAME: Theresa McCarthy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mrs. Winifred Chambers 230 S. Conkling St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 12 hours

DUE TO

(B) Moderate Malignant Hypertension — 5½ years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6-7-49, 19__, *to* 12-12-49, 19__, *that I last saw the deceased alive on* 12-11-49, 19__, *and that death occurred at* 7:55 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John Cockentini, M. D. | 230 S. Conkling St | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Oak Lawn | Colgate, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 14 1949 | Curtis Holtzman, M.D. | Ullrich Funeral Home 2008 Orleans St. |

VS 150

83a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C8084O

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

C8084O

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HYLAND, EDWARD F.

2. DATE OF DEATH: 12/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 891 N. LOMBARD ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | W | 12/23/1884 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman
10B. KIND OF BUSINESS OR INDUSTRY: For City
11. BIRTHPLACE (State or foreign country): Balto. MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Hyland
14 MOTHER'S MAIDEN NAME: Margaret Cowan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16 SOCIAL SECURITY NO.
17 INFORMANT: Miss Anna Hyland ADDRESS: 891 W. Lombard St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Peritonitis + Hemorrhage

DUE TO

(B) Perforated Peptic Ulcer

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 11, 1949, *to* Dec. 12, 1949, *that I last saw the deceased alive on* Dec. 12, 1949, *and that death occurred at* 6:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. Leonard Dresser M. D.
23B ADDRESS: Sinai Hospital
23C DATE SIGNED: Dec. 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/16/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D LOCATION (City, town, or county) (State): 4300 Old Frederick Rd.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: Deputy for Williams, M.D.
25 FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 901 Hollins St.

DS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1179

G80841 — BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80841 — Registered No.

1. NAME OF DECEASED (Type or Print): SAMUEL MOORE JOHNSON

2. DATE OF DEATH: 12/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNION MEM HOSP.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: BALT.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 401 LYMAN AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M | MAR 2, 1882 | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CIVIL ENGINEER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: WM. JOHNSON
14. MOTHER'S MAIDEN NAME: EMMA STEWART
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs. Gertrude J. Johnson — ADDRESS: 401 Lyman Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: about 1 hr
DUE TO
(B) Carorary thrombosis
DUE TO
(C) Carorary atherosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/11, 1949, *to* 12/12, 1949, *that I last saw the deceased alive on* 12/11, 1949, *and that death occurred at* 1:45 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Merrill T. Nelson | Union Mem Hosp. | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-14-1949 | Druid Ridge | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: Esther Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John O. Mitchell Sons — 1900 Eutaw Place

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80842 **CERTIFICATE CORRECTED** 12-22-49 C80842

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ARTHUR W. CHESSHER ~~CHESSER~~ — 2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: ~~Maryland~~ Alabama, B. COUNTY: Russell
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Phenix City, Alabama
D. STREET ADDRESS (If rural, give location): ~~122 Market Place~~ 1100 Seale Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Divorced | Apr. 16, 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - | - | Columbus, Georgia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| - | - |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | 420-20-6797 | Mrs. A. C. Edwards, 1100 Seale Rd., Phenix City, Ala |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Fatty Degeneration of Liver | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George C. Merrill M.D. | | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Dec 16 Columbus Ga | Girard Cemetery | Ga. Phenix City, Ala. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 14 1949 | Huntington Williams, M.D. | Ellis Funeral Home 5118 Guyton Rd |

VS 151

12B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80843 ✓ C80843

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

430,0 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Roland Myers 2111 S-4

2. DATE OF DEATH: DEC 10 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 12 04
D. STREET ADDRESS (If rural, give location): 2205 Barclay St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | Colored | married | Dec. 29 1925 | 24 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Hat Cleaners | Balto. Md | U.S. |

13. FATHER'S NAME: Charles Myers

14. MOTHER'S MAIDEN NAME: Bertha Smart

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | Johns Hopkins Hospital |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subacute bacterial endocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?6 wks.

DUE TO (over)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-9-, 1949 *to* 12-10-, 1949 *that I last saw the deceased alive on* 12-10-, 1949, *and that death occurred at* 1245 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Philip S. Wagley M. D. | JOHNS HOPKINS HOSPITAL | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-14-49 | Pleasant Rest | Towson Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | [illegible] for Williams, M.D. | Bryant Mamie Wright | 910 721 Ausquith St. |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80814 ✓ X C80814

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 1949

Registered No. 4/13

1. NAME OF DECEASED (Type or Print): Richard Reamer

2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): Route # 5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Child | 7-E-45 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Reamer | Julia A Spencer |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Leukemia, Acute | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Bronchopneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-12, 1949 *to* 12-13, 1949 *that I last saw the deceased alive on* 12-13, 1949, *and that death occurred at* 5.50 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. C. Robertson M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Solems | Sewell Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Livingston Williams, M.D. | Wm Watts | Westminster Md |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

74a

C80845 ✓ C80845

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 593

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Lee Sr.

2. DATE OF DEATH: Dec 12, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: md; B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2522 Madison ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 13 J J

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2522 Madison ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| m | C | m | Feb 29, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor | apt | Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Lee | Elizabeth Phillips |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Clara Lee | 2522 Madison ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

DUE TO

(B) Jaundice & Hepatitis — 1 month

DUE TO

(C) Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/1 49 *to* 12/12 49, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 3:10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jas. R. Blake M. D. | 1603 N. Carrollton | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-15-49 | Mt Auburn | md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 | Williams, M.D. | George D. Kelson | 1303 Presstman st |

VS 150

131B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80846

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

C80846

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sallie Morris

2. DATE OF DEATH: 12-11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1715 Mc Kean Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 15-0
D. STREET ADDRESS (If rural, give location): 1715 Mc Kean Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | Oct. 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Va. | U.S.A. |

13. FATHER'S NAME: James Dunlap

14. MOTHER'S MAIDEN NAME: Sarah ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| No | | |

17. INFORMANT: James Morris ADDRESS: 1715 Mc Kean Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage

DUE TO

(B) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 9 1949 *to* Dec 11 1949 *that I last saw the deceased alive on* Dec 11 1949, *and that death occurred at* 2 P.M. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Julius S. White M.D. | 1802 Penna Ave. | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-16-1949 | Mt. Auburn Cem. | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR: Mrs Katie R. Williams ADDRESS: 3221 Sebrooke St

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

82a

C80847 C80847

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Freddie Frederick Brown
2. DATE OF DEATH: 12-11-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1047 Vine St.
C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1047 Vine St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Single | May 5, 1904 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Balto. Md. | U.S.A. |

13. FATHER'S NAME: John W. Brown
14. MOTHER'S MAIDEN NAME: Henrietta Scribner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Marie Hall | 1047 Vine St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Tuberculosis | 6 months |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 2, 19 49 *to* Dec 11, 19 49 *that I last saw the deceased alive on* Dec 14, 19 49 *and that death occurred at* 9:15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William H. Watts M. D. | 5152 Loch Raven Blvd | 12/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-15-1949 | W. H. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Hunter for Williams, M.D. | Mrs Kate R. Williams | Schroeder St |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

128

G80848 ✓ G80848

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 6 23

Registered No.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | JOSHUA C. SNOWDEN | 2. DATE OF DEATH | December 12, 1949 |

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1018 Vine Street
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1018 Vine Street 18-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | | March 1901 | 48 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laboper | B+O R.R. | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Clarence Snowden | Alice ? ✓ |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Hazel Matthew | 1018 Vine St. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18 | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Syphilitic aortitis | |
| | DUE TO | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| | DUE TO | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22 *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | [X] | 12-12-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-17-1949 | Mt. Auburn Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | [illegible] | Mrs Kate R. Williams | 324 N Schroeder St |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

30D ✓

C80849

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80849

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH MEISENHALDER

2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore (Yrs. Mos. Days):

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1318 Walters Avenue 77-38

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months Days | If under 24 hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | married | May 18, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| cutter | Leather Industry | Baltimore, Md. | |

13. FATHER'S NAME: Joseph Meisenhalder

14. MOTHER'S MAIDEN NAME: Henrietta ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 212-09-3760

17. INFORMANT: Mrs. Helena Meisenhalder, 1318 ADDRESS Walters

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Contusion of brain.
DUE TO Fractured ribs.
Fractured pelvis.
(B) Intracranial hemorrhage
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1200 Blk. East Belvedere Avenue

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 13, 1949 7 [illegible] p.m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto 27/38

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George L. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR [X]

23C. DATE SIGNED: 12-14-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Oaklawn | Balto Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Leonard J. Ruck, ADDRESS 5305 Harford Road.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

170 c

Dr. Stevens G80850 G80850

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

177 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank B. Scoggins

2. DATE OF DEATH: Dec. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3317 Kenyon Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3317 Kenyon Avenue 26-03

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar. 22, 1886
9. AGE (In years last birthday): 63 | If Under 1 Year Months Days | If Under 24 Hours Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor
10B KIND OF BUSINESS OR INDUSTRY: Penn. R.R.
11. BIRTHPLACE (State or foreign country): Augusta, Georgia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Scoggins
14 MOTHER'S MAIDEN NAME: Mary Barrett
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: Mrs. Theresa Scoggins
ADDRESS: 3317 Kenyon

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastasis of Carcinoma Prostate & Brain & bones.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22 *I hereby certify that I attended the deceased from* Dec. 1947 *to* Dec. 13, 1949, *that I last saw the deceased alive on* 12/13, 1949 *and that death occurred at* 8.25 *m., from the causes and on the date stated above.*

23A. SIGNATURE: H. B. Stevens M. D.
23B ADDRESS: 3400 Eadman Ave
23C DATE SIGNED: 12/14/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: 12-17-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25 FUNERAL DIRECTOR: Leonard J. Ruck
ADDRESS: 5305 Harford Road

VS 150

516

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80851 BALTIMORE CITY HEALTH DEPARTMENT No. 0 G80851

BIRTH NO. G80851

# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Louis Weissenborn

2. DATE OF DEATH: 12/13/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2805 Presstman St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2805 Presstman St. 16 07

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 10/25/1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Night Watchman | Arundel Corp. | Baltimore | USA |

13. FATHER'S NAME: Paul Weissenborn

14. MOTHER'S MAIDEN NAME: Laura Sprengle

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | | Rose Weissenborn | 2805 Presstman St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | Interval between onset and death |
|---|---|---|
| (A) | Cerebral Hemorrhage | 2 days. |
| DUE TO | | |
| (B) (1) | Chronic Nephritis | 5 yrs. |
| DUE TO | | |
| (C) | Arterio-Sclerotic Heart Disease | 10 yrs.? |
| | - Hypertrophied Prostate | 2 wks.? |

ANTECEDENT CAUSES, DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No. | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 28, 1947 *to* Dec. 13, 1949 *that I last saw the deceased alive on* Dec 13 1949, *and that death occurred at* 10.50 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Earl L. Chambers M. D. | 4108 Liberty Hts. Ave. | 12/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Western | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Huntington Williams, M.D. | John T. Stansbury | 2700 Edmondson Ave |

VS 150

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80852 X ✓ G80852

BIRTH NO. G80852

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

Registered No.

1. NAME OF DECEASED (Type or Print): Gertrude Todhunter

2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hosp.

c. Length of stay in Baltimore: 2 months (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 9713 Commercial Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chicago Ill.
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | 2/23/1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Chicago (Chicago) Ill. | |

13. FATHER'S NAME: Richard Phillips

14. MOTHER'S MAIDEN NAME: Anna Stewart

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Geo. M. Todhunter | (same) |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pontine Hemorrhage | 24-48 hrs. |
| DUE TO (B) | Cerebral arteriosclerosis | indefinite |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Chronic Cor Pulmonale | at least one year |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-9-49, 19 *to* 12-14-49, 19, *that I last saw the deceased alive on* 12-14, 1949, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph Shear M. D. | West Balto Gen Hosp | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Cedar Park Cem. | Chicago Ill. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | Huntington Williams, M.D. | Lansaha Funeral Home | 2401 Belair Rd |

VS 150

8.3a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80853

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.1

C80853
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Estella Grace Berman

2. DATE OF DEATH: Dec. 12/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2239 W. Fayette St

C. Length of stay in Baltimore: Yrs. Life, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
D. STREET ADDRESS (If rural, give location): 2239 W. Fayette St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | July 8 1885 | 64 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sales Lady | Stewart & Co | Balto. Md. | USA. |

13. FATHER'S NAME: George MacCarter

14. MOTHER'S MAIDEN NAME: Sadie Woodall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | 214-03-1495 | George Berman | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic C.V Disease — 2 yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from July, 1949 to Dec 12, 1949 that I last saw the deceased alive on Dec 12, 1949, and that death occurred at 6:50 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. P. Sulzinake M. D. | 1943 W Belto St | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 15/49 | Western Cemetery | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | ~~Mrs. Williams, M.D.~~ | H. R. Gilbert & Son | 130 Eutaw Pl |

VS 150

(1931)

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80854 G80854

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 85

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LETTIE Elizabeth Kenny

2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1630 E. Biddle Street

c. Length of stay in Baltimore: 38 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTimore
D. STREET ADDRESS (If rural, give location): 1630 E. Biddle Street 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FeMale | Colored | Widowed | Oct. 30, 1895 | 54 | 1 | 14 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | St. Mary County, Md. | U.S.A. |

13. FATHER'S NAME: Daniel Gross

14. MOTHER'S MAIDEN NAME: Mary Ellen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Bernice Barnes | 1630 E. Biddle St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral Hemorrhage | Several Days |
| DUE TO | | |
| (B) | CARDIO VASCULAR Disease | Unknown |
| DUE TO | | |
| (C) | Cholecystitis | Unknown |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* September 10, 1949, to December 13, 1949, *that I last saw the deceased alive on* Dec. 12, 1949, *and that death occurred at* 8:15 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard H. Hunt M. D. | 1631 W. Franklin St. | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 17 49 | Mt Calvary Cem. | B.C. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 14 1949 | [illegible] | Mrs Robert A. Ellison Daughter | 939 1129 N. Caroline St. |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80855

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G80855 | 53 | Registered No. G80855

1. NAME OF DECEASED (Type or Print): HAND. ALICE

2. DATE OF DEATH: 12-12-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQ HOSP
c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 22-18
D. STREET ADDRESS (If rural, give location): 3721 W GARRISON AVE

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 6-22-1867
9. AGE (In years last birthday): 82 — If under 1 Year: Months: 5, Days: 20; If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JOHN TILLERY
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT — ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) BRONCHO-PNEUMONIA — DUE TO FLEXURE OF COLON — INTERVAL BETWEEN ONSET AND DEATH: 1 WK.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) CARCINOMA OF HEPATIC FLEXURE — DUE TO MET TO LIVER.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C) DUE TO METASTES, COMMON DUCT OBSTRUCTION

19A. DATE OF OPERATION: 11-27-49
19B. MAJOR FINDINGS OF OPERATION: AS ABOVE (B)
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-23, 1949 *to* 12-12, 1949, *that I last saw the deceased alive on* 12-12, 1949, *and that death occurred at* 5:30 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: J W Borkowic M. D.
23B. ADDRESS: FRANKLIN SQ Hosp
23C. DATE SIGNED: 12-12-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Jackson Family Cemetery
24D. LOCATION (City, town, or county) (State): Dellerville Va

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: Thomas J. Williams M.D.
25. FUNERAL DIRECTOR — ADDRESS: Loring Byers 5005 Pk Heights Ave

46E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G808:56 G808:56

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. 16-67

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES L. DIDLAKE

2. DATE OF DEATH: Dec. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1525 Ellamont Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1525 Ellamont Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widow | Dec. 11, 1864 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter, retired | | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| (Unknown) Didlake | (Unknown) Proctor |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Elmer M. Didlake, 1301 Washington Blvd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 1 week |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Hypertensive Cardio Vascular Disease | ? |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-3 19 49 *to* 12-13 19 49, *that I last saw the deceased alive on* 12-13 19 49, *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John P. Mulvey Jr. M. D. | 1227 Eutaw Blvd | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 15 1949 | Lucius Lee Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

937

G80857 G80857

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James J. Cunningham

2. DATE OF DEATH: 12/13/49 8:45 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1309 Ballard Way

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1309 Ballard Way

| 5. SEX | 6. COLOR OR RACE | 7. ~~SINGLE~~, MARRIED, ~~WIDOWED DIVORCED~~ (specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 10/14/1907 | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Boiler | Bethlehem Ship Yard | Wilkesbarre Pa | |

13. FATHER'S NAME: John Cunningham

14. MOTHER'S MAIDEN NAME: Edith Bunnier

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 189-01-3429 | Ross Cunningham | 1309 Ballard Way |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C) Myocarditis.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 10 19[illegible], *to* Dec 10, 19[illegible], *that I last saw the deceased alive on* Dec 10, 1949, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harry Gilbert M. D. | 23B. ADDRESS: 600 S Eastern Av | 23C. DATE SIGNED:

24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify): Burial | 24B. DATE: 12/16/49 | 24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel | 24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 15 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Wm Cook Inc | ADDRESS: 1217 St. Paul St.

VS 150

13 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80858 For Medical Examiner O.K. G80858

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Emma Borneman

2. DATE OF DEATH: 12/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balt. General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-02
D. STREET ADDRESS (If rural, give location): 2102 Bolton St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | 10/6/1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Germany | U.S. |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | | Martha Conner 2102 Bolton St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pneumonia Lobar
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12/11 1949 *to* 12/12 1949, *that I last saw the deceased alive on* 12/12 1949, *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Warren H. Wood M.D. | West Balt. General Hosp. | 12/13/49 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~OR CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | Wm Cook Inc. 1217 St. Paul St. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

939

G80859

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80859

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frederick J. Bock

2. DATE OF DEATH: 12/13/49 — 12:50 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 609 Wellesley st
c. Length of stay in Baltimore — Yrs. Mos. Days:

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 2 C C 6
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto
D. STREET ADDRESS (If rural, give location): 609 Wellesley St

5. SEX: Male
6. COLOR OR RACE: White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED, DIVORCED~~ (Specify): Married
8. DATE OF BIRTH: 4/20/1875
9. AGE (In years last birthday): 74 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Slater
10B. KIND OF BUSINESS OR INDUSTRY: Chesapeake Roofing Co
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Herman Bock
14. MOTHER'S MAIDEN NAME: Louisa Zinderling
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 216-03-7120 A
17. INFORMANT: Lisette Bock — ADDRESS: 609 Wellesley St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: several days

DUE TO

(B) Myocardial insufficiency — several years

DUE TO

(C) Generalized arteriosclerosis — many years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/12, 1949, to 12/13, 1949, *that I last saw the deceased alive on* 12/13, 1949, *and that death occurred at* 12:50 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 3325 Frederick Rd
23C. DATE SIGNED: 12/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/15/49
24C. NAME OF CEMETERY OR CREMATORY: Western
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 15 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: Wm Cook Inc. — ADDRESS: 1217 St. Paul st

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93D

G80860

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

42-1

G80860

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): EURITH LOUTISHA JONES

2. DATE OF DEATH: Dec. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5208 Tramore Rd.
c. Length of stay in Baltimore: Yrs. Mos. Dys.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2827 Parkwood Ave. 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Widow | Sept. 20, 1856 | 93 | 2 mo | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert Barnes | Sarah A. Smith |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | none | Mr. A. A. Jones | 2827 Parkwood Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chr. Myocarditis | 1939 |
| DUE TO (B) | Chr. Interstitial Nephritis | 1939 |
| DUE TO (C) | Arterio Sclerosis | 1939 |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1 – 1949 *to* Dec. 12, 1949 *that I last saw the deceased alive on* Dec. 11, 1949, *and that death occurred at* 6:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul J. Brown M.D. | 1663 N. North Ave. | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | St. Mary's Cem. | Hampden, Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | [illegible] | WM. J. TICKNER & SONS, | Balto. Md. |

VS 150

131a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80861

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80861

Registered No.

1. NAME OF DECEASED (Type or Print): LOUISE AGNES MAISCH

2. DATE OF DEATH: Dec. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 836 Edmondson Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 836 Edmondson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Jan. 30, 1858 | 91 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor (rtd) | Laundry | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John F. Maisch | Caroline von Bodenhauser |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Miss Irene C. Maisch | 836 Edmondson Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

(B) Arteriosclerotic — INTERVAL BETWEEN ONSET AND DEATH: Since 1932

DUE TO

(C) Cardio-vasculor disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-14-32 *to* 12-13-49, *that I last saw the deceased alive on* 12-10, 1949, *and that death occurred at* 9 AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George L. Kuiper M. D. | 3030 Edmondson Ave. | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

927

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80862

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80862

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERTHA ZUMSTEIN

2. DATE OF DEATH: Dec. 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2816 Walbrook Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2816 Walbrook Ave. 15 06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | widow | Mar. 20, 1883 | 66 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | home | Baltimore, Md. | |

13. FATHER'S NAME: Frederick Spangenberg

14. MOTHER'S MAIDEN NAME: Amelia

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mrs. Jeannette Berg | 308 Elizabeth Ave., Pittsburgh, Pa |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Insufficiency

DUE TO

(B) Arteriosclerosis, coronary

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Hypertensive Cardio-Vascular Renal Syndrome.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from June 1, 1949, to December 12, 1949, that I last saw the deceased alive on December 3, 1949, and that death occurred at 11:00 p. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry W. D. Hollyes M. D. | 3308 W. North Ave. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 12/16/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80863

BIRTH NO. 49-37468

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

770.0

G80863

Registered No.

1. NAME OF DECEASED (Type or Print) Bobby Boy Tillman

2. DATE OF DEATH Dec. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 13
D. STREET ADDRESS (If rural, give location) 1009 Rectory Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Infant | 12/14/49 | | | 2 0 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William | Davis Erb |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia Intra
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* [illegible] *to* [illegible], 19[illegible], *that I last saw the deceased alive on* [illegible], 19[illegible], *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | [illegible] | [illegible] |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 16 Dec 1949 | St Mary's Hampden | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Emmett Joyce Williams, M.D. | Austin C. Donovan | 3818 Roland Ave |

VS 150

161C

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G80864

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.0

G80864

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Guoto (GUISTO) Cesenaro (CESENARO)

2. DATE OF DEATH: Dec. 14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp
c. Length of stay in Baltimore: Yrs. Mo. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
413 N. Washington St
c. CITY OR TOWN (If outside corporate limits, write RFD and give township): Balto Md 6-04
D. STREET ADDRESS (If rural, give location): 413 N. Washington St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Married | July 5, 1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | Tailor (self) | Italy | |

13. FATHER'S NAME: Julius Cesenaro

14. MOTHER'S MAIDEN NAME: Lucy

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | none | Howard Goldsborough | 2237 N. Charles St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary edema
DUE TO
(B) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-9, 1949, *to* 12-14, 1949, *that I last saw the deceased alive on* 12-14, 1949, *and that death occurred at* 6³⁰ A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerome Gaber, M.D. | Sinai Hosp. | 12/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Dec. 16/49 | Holy Redeemer | Balto Md |

| DATE RECEIVED BY REGISTRAR (Month) (Day) (Year) | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | acting for Williams, M.D. | Philip Herring Sons | 2014 Orleans St |

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80865

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80865

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jacob Fishell

2. DATE OF DEATH: Dec. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1707 N. Hilton St.,

c. Length of stay in Baltimore: 00 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1707 N. Hilton St.,

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 18, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Engineer | B. & O. R.R. | Va. | |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Tabitha A. Fishell | 1707 N. Hilton |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Myocarditis | 5 Mo. |
| | DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Cardiovascular disease | about 5 Mo |
| | DUE TO | | |
| | (C) | Arterio-sclerosis | ? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from June 9/49, 19__, to Dec 14, 1949, that I last saw the deceased alive on Dec 13, 1949, and that death occurred at 9 a m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Durbin M. D. | 2220 Harrison Blvd | Dec 13 '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-16-49 | Lorraine Park | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Kenneth Williams, M.D. | G. Howard Strong | 3207 W. North Ave., |

VS 150

93D

Correct age, especially important. Physicians: please write the cause of death plainly. Spell out every word.

C80866

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

154 Registered No. C80866

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Peter Kangas

2. DATE OF DEATH: Dec.13,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3023 Gwynns Falls Parkway
c. Length of stay in Baltimore: 26-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 15-47
D. STREET ADDRESS (If rural, give location): 3023 Gwynns Falls Parkway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug.8,1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Restaurant | | Greece | |

13. FATHER'S NAME: Anastasias Kangas

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | none | Mrs.Josephine G.Kangas | 3023 Gwynns Falls Prkwy. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Rectum | 2 yrs. |
| DUE TO (B) | Generalized Metastasis | 6 mos. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Dec. 13, 1949 *that I last saw the deceased alive on* Dec. 13, 1949 *and that death occurred at* 7:00 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter A Johnson | 3835 Forty Six Falls P Kwy | 12/13/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12-16-49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | G.Howard Strong | 3207 W.North Ave., |

VS 150

467

Correct age if especially important. Physicians: please write the cause of death clearly and legibly.

G80867 X ✓ E 8 12.4 G80867

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) GERTRUDE M KELBAUGH — N-808.7

2. DATE OF DEATH December 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION ("If not in hospital or institution, give street address or location")
University Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Upper Garrison
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Married | Mar 5 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Carroll Co | U.S. |

13. FATHER'S NAME Richard Hoffnagle

14. MOTHER'S MAIDEN NAME Martha E Frank

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | None | Wm A Kelbaugh | Garrison Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Shock due to fractures of pelvis and left hip, and lacerations and fractures of left hand.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Myocardial hypertrophy. Fatty degeneration of liver.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | highway | Reisterstown & Valley Roads |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK [ ] | NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| December 14, 1949 5p m. | | | pedestrian struck by station wagon |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D | | Dec. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 17-49 | Pleasant Hill | Balto Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | J F Elmer & Sons | Reisterstown Md |

VS 151

170c ✓

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80868 ✓ 590 G80868

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Clara Brayboy

2. DATE OF DEATH: 12/12/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 607 S. Green St
c. Length of stay in Baltimore: 8yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-2
D. STREET ADDRESS (If rural, give location): 621 S. Fremont Av

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (in years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Single | 7/3/1909 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laundress | Domestic | N.C. | U.S.A. |

13. FATHER'S NAME: Charles Brayboy

14. MOTHER'S MAIDEN NAME: Mary

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N | None | Mary Cherry | 621 S. Fremont Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Acute myocarditis — DUE TO — 1 month

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-1, 1949, *to* 12-12, 1949, *that I last saw the deceased alive on* 12-12-49, 19____, *and that death occurred at* 5 a.m. p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Bonnell Benjamin M.D. M. D. | 854 Shap St. | 12-13-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Mt Auburn | Beltsville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 26. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 1-1949 | Emily Jr. Williams, M.D. | Chas. H. Wilson | 5[illegible] Edmondson Av |

130

G80863 ✓ 450 G80863

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): MARY ANNA KLUMP

2. DATE OF DEATH: 12/12/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — I622 Hanover St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 22-02

c. Length of stay in Baltimore — Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): I622 Hanover St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | 12/3/1863 | 86 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home | Baltimore | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Family - | Same |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12-18 hrs

DUE TO

(B) Advanced Arteriosclerosis — 10 yrs

DUE TO

(C) Senility — 5-6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June, 1949, *to* 12-12-49, 19___, *that I last saw the deceased alive on* 12-12-49 19___, *and that death occurred at* 7.35 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. S. Baugh M.D. M. D. | 642 North Dallas | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/16/49 | Cedar Hill | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams M.D. | Jas. L. McCauley | 130 E. Fort Ave. |

VS 150

97

G80870 ✓ BALTIMORE CITY HEALTH DEPARTMENT E 971.0 G80870

# CERTIFICATE OF DEATH

BIRTH NO. 49-13713 Registered No. N-933

1. NAME OF DECEASED (Type or Print): CHARLES E. MULLER

2. DATE OF DEATH: December 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits write RURAL and give township): Baltimore 25-05
D. STREET ADDRESS (If rural, give location): 1002 Hacht Court Hatch lot,

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | S | 7/7/49 | | 5 | 7 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore | |

13. FATHER'S NAME: Charles E. Muller Sr.

14. MOTHER'S MAIDEN NAME: Thelma Stolte

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Family - Same | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO Aspiration of vomitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 1002 Hacht Court |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 12-14-49 ? m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Aspiration of vomitus |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/17/49 | Loudon Park | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | James L. McEvoy | 130 E. Fort Ave |

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1950

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G808.1 ✓ 331 G808.1

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MICHAEL A. SCHMIDT

2. DATE OF DEATH: December 13, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 720 S. Clinton St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 26-11
D. STREET ADDRESS (If rural, give location): 720 S. Clinton St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | August 10, 1864 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Can Co. | Germany | U.S.A. |

13. FATHER'S NAME: Andrew Schmidt

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | — |

17. INFORMANT: Aloysius Schmidt ADDRESS: 720 S. Clinton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks.

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 6, 1946 *to* Dec 13, 1949 *that I last saw the deceased alive on* Dec 12, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton Isaacs M. D. | 1424 W. Fayette St | Dec 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-16-49. | Sacred Heart Cemetery | 4701 German Hill Rd. Balto. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | Charles L. Zeile, | 901 S. Conkling St. |

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G808'72 ✓ G808'72

BIRTH NO. 170

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lula May Summit

2. DATE OF DEATH: 12/11/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1824 Belt St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-4
D. STREET ADDRESS (If rural, give location): 1824 Belt St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Divorced | June 6, 1909 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Md | |

13. FATHER'S NAME: William W. Neal

14. MOTHER'S MAIDEN NAME: Addie Pearce

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | — |

17. INFORMANT: Mrs Addie Shakels ADDRESS: 1824 Belt St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma Left breast — INTERVAL BETWEEN ONSET AND DEATH: 4 years
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1945 | Carcinoma left breast | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1947, *to* 12-11, 1949, *that I last saw the deceased alive on* 12-11, 1949, *and that death occurred at* 5:50 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John P. Ulrich Jr. M. D. | 1227 Wash Blvd | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/15/49 | Glen Haven | Annapolis Blvd, Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 15 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John F. Kenny Inc. ADDRESS: 715 Eight St

50

G80873

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143

Registered No. G80873

1. NAME OF DECEASED (Type or Print): **Wallace Norman Aler**

2. DATE OF DEATH: **December 14, 1949**

3. PLACE OF DEATH:
A. **Baltimore City, Maryland**
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **3820 Beech Avenue**
c. Length of stay in Baltimore: Yrs. **Life** Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore** 13-07
D. STREET ADDRESS (If rural, give location): **3820 Beech Avenue**

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 16, 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pajama Mfg. | Knothe Brothers | Maryland | U S A |

13. FATHER'S NAME: **William Aler**

14. MOTHER'S MAIDEN NAME: **Mary Kilgrove**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: **212-07-4634**

17. INFORMANT: **Lida E. Aler** ADDRESS: **3820 Beech Avenue**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myo-Cardio-Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

(B) Hypertension — 10 yrs.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1930 *to* Dec 14, 1949, *that I last saw the deceased alive on* Dec 14, 1949, *and that death occurred at* 12 30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hubert M. Foster M. D. | 2424 St Paul | Dec 14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 16, 1949 | Meadowridge Memorial Park | Howard Co., Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, MD | Burgee Funeral Home | 3631 Falls Road |

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G80874 ✓ G80874

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 234

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FLORENCE D. HAMPE

2. DATE OF DEATH: Dec 14. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 602 Bartlett Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN: Baltimore 9-08 (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location): 602 Bartlett Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Mar. 18 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Baltimore Md | |

13. FATHER'S NAME: John J. Lehman

14. MOTHER'S MAIDEN NAME: Marian Rodman

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | | Florence Mildred Gude | 602 Bartlett Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Central Hemorrhage | 1 week |
| DUE TO | | | |
| ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Central Arteriosclerosis | 6 mos |
| DUE TO | | | |
| | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 9 1949, to Dec. 14, 1949, *that I last saw the deceased alive on* Dec. 13 1949, *and that death occurred at* 7.50a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas F. White M.D. | 3809 Greenmount Ave | 12/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 17 1949 | Parkwood | Balto-Co-Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Registrar for Williams, M.D. | Jno. Wm. John H. Tenfelde Son | 5311 Edmondson Ave. |

VS 150

83a

G808.75 ✓ G808.75

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. 331

1. NAME OF DECEASED (Type or Print): KATHERINE RINGROSE

2. DATE OF DEATH: Dec 14 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1134 W. Hamburg St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-02
D. STREET ADDRESS (If rural, give location): 1134 W. Hamburg St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Feb 18, 1880 | 69 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Kelly
14. MOTHER'S MAIDEN NAME: Rose Duke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: George W. Ringrose
ADDRESS: 1134 W. Hamburg St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemmorrhage | 1 day |
| DUE TO | Hypertension | 1 yr. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12.14.49 19__ *to* 12.14.49 19__, *that I last saw the deceased alive on* 12.14.49 19__, *and that death occurred at* 11 55 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul Schonfeld M. D. | 2301 Annapolis Rd. | 12.15.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 17 1949 | New Cathedral | Balto - City - Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 15 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Wm. Wm. John W. Tenfelde Son
ADDRESS: 5311 Edmondson Ave.

VS 150

83a

C808'76 ✓ E 77 C808'76

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): LOUVENIA JESSE N-968

2. DATE OF DEATH: December 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1910 E. Baltimore Street 6-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months Days | If under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Dec. 15, 1898 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Coat cleaner | Clothing factory | Wise, Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joel Wheatley | Jennie Jessee |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No. | | Alfred Jessee 1910 E. Baltimore St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxiation due to inhalation of illuminating gas.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 1910 E. Baltimore Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 15, 1949 ? Am. | | Gas heater on but unlit |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Dec/ 15, 1949 | Norton, Virginia. | Norton, Virginia. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 15 1949 | Huntington Williamson, M.D. | Ullrich Funeral Home 2008 Orleans St. |

VS 151

DEC 15 1949

163H ✓

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C808.7 ✓ X 1-20.0 C808.7

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen C. Farmer

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chambersburg, Pa
D. STREET ADDRESS (If rural, give location): 867 Broad St

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | 4-7-98 | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pay Roll Clerk | Canned Foods | Pa | |

13. FATHER'S NAME: Worthington - Phillip E.

14. MOTHER'S MAIDEN NAME: ?Mary Hockensmith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Myocardial Infarction | 9 days |
| DUE TO | Due to Coronary Artery Occlusion | |
| (B) | Arteriosclerotic Heart Disease | 5 years |
| DUE TO | | |
| (C) | Cerebral Embolus | 3 days |
| | Malignant Melanoma, Rt. Eye | 16 mos. |

19A. DATE OF OPERATION: Enucleation Rt Eye 11/29/49

19B. MAJOR FINDINGS OF OPERATION: Malignant Melanoma, Extending beyond orbit

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 11/2 *, 19*49 *to* 12/15 *, 19*49 *, that I last saw the deceased alive on* 12/15 *, 19*49 *, and that death occurred at* 1.2 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Hartmann M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 12/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12/15/49

24C. NAME OF CEMETERY OR CREMATORY: Chambersburg, Pa.

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: DEC 15 1949

REGISTRAR'S SIGNATURE:

25. FUNERAL DIRECTOR: Wm. V. Tickner & Sons - H. & Pa. Aves.

ADDRESS:

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Hunting ton Williams, Md

55E

G808'78

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

20 4.1

Registered No. G808'78

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Corennie V. DeGrange

2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Buckeystown
D. STREET ADDRESS (If rural, give location): 1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | 4-3-1927 | 22 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H. W | | Md. | |

13. FATHER'S NAME: John W. Hill

14. MOTHER'S MAIDEN NAME: Anna Hartman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Charles A DeGrange | Buckeystown Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myelogenous Leukemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 5, 1949, *to* Dec 15, 1949, *that I last saw the deceased alive on* Dec 15, 1949, *and that death occurred at* 12 45 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Kyle G. Swisher Jr M. D. | Univ. Hosp. | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-17-49 | Mt Olivet | Frederick Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | M R Eichelberger & Son | Frederick Md |

VS 150

74a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G808,79

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.1 Registered No. G808,79

1. NAME OF DECEASED (Type or Print): PATRICK J. O'GRADY
2. DATE OF DEATH: Dec. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1821 W. Fayette St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 70-01
D. STREET ADDRESS (If rural, give location): 1821 W. Fayette St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Feb. 1, 1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Gatekeeper | B. & O. R.R. | Ireland | U.S. |

13. FATHER'S NAME: Owen O'Grady
14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | | Mrs Delia O'Grady | 1821 W. Fayette St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CORONARY OCCLUSION | 1 week |
| DUE TO (B) | ARTERIOSCLEROSIS, GENERALIZED | 2 1/2 yrs. |
| DUE TO (C) | HIGH BLOOD PRESSURE | 2 1/2 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April 27, 1949 *to* Dec. 13, 1949, *that I last saw the deceased alive on* Dec. 10, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gilbert E. Rudman M. D. | 2517 W. Balto St. | Dec. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 16, 1949 | Cathedral Cem. | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 15 1949 | Huntington Williams, M.D. | George A. Farley | Fulton Ave & Fayette St. |

DEC 16 1949

94a

C80880

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80880 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lillian McArthur

2. DATE OF DEATH: Dec. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSP...

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 10-01
D. STREET ADDRESS (If rural, give location): 1424 E. Chase St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | | 4-22-10 | 39 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | No. Carolina | |

13. FATHER'S NAME: Burgess Rogers

14. MOTHER'S MAIDEN NAME: Mamie Sledge

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Chronic glomerulonephritis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/21 19 49 *to* 12/14, 19 49, *that I last saw the deceased alive on* 12/14, 19 49, *and that death occurred at* 8 15 A. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter S. Ames M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 18 1949 | Mt Olivet Cem | Bal. A. County |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 16 1949 | Hunter Williams, M.D. | McHenry Gross 1408 Ashland Ave |

VS 150

1318

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80831

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 49

G80831

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) SARAH ADLER

2. DATE OF DEATH 12-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 869 West Lombard St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 869 West Lombard St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years if over 1 year) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | | 37 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Heyman Drager

14. MOTHER'S MAIDEN NAME Rose

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Martin Adler ADDRESS 869 W Lombard

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

(B) Hypertension Cardio Vascular Renal Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/18/30/49 *to* 12/15, 19 49, *that I last saw the deceased alive on* 12/13, 19 49, *and that death occurred at* 6-17 m., *from the causes and on the date stated above.*

23A. SIGNATURE Jno. L. Blum M. D. | 23B. ADDRESS 1115 N Calvert St | 23C. DATE SIGNED 12/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12-16-49 | 24C. NAME OF CEMETERY OR CREMATORY United Hebrew | 24D. LOCATION (City, town, or county) Balto (State) Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 16 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Jack Lewis | ADDRESS 2100 Eutaw Pl

VS 150

131a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80882

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 17°

C80882

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): CELIA ADLER

2. DATE OF DEATH: 12/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SINAI HOSPITAL

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-01
D. STREET ADDRESS (If rural, give location): 1673 West North Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | | 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Usher
14. MOTHER'S MAIDEN NAME: Sarah
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles Adler ADDRESS: 1637 W North

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis
DUE TO
(B) Metastatic Ca of breast
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ✓ NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/1 1949 to 12/14 1949 *that I last saw the deceased alive on* 12/14 1949 *and that death occurred at* 4:40 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Wm. Krakauer M.D.
23B. ADDRESS: Sinai Hospital
23C. DATE SIGNED: 12/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-16-49
24C. NAME OF CEMETERY OR CREMATORY: Bnai Israel
24D. LOCATION (City or town, or county) (State): Butte Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Rewsdne ADDRESS: 2100 Eutaw Pl

VS 150

50

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80883

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

3 31

G80883

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LENA SHERR

2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General

C. Length of stay in Baltimore: 41 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1536 Morland Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 57
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Romania
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Louis Sherr
ADDRESS: 1536 Morland Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 hour

19A. DATE OF OPERATION: ✓
19B. MAJOR FINDINGS OF OPERATION: ✓
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June 1949 *to* Dec. 15, 1949, *that I last saw the deceased alive on* Dec. 15, 1949 *and that death occurred at* 12:00 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Benj. Sanders M.D.
23B. ADDRESS: 2138 W. Northern
23C. DATE SIGNED: 12/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-16-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): Balto Md Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

83a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80834 X ✓ 420.1

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80834

1. NAME OF DECEASED (Type or Print) TAYLOR, JOHN CAREY

2. DATE OF DEATH Dec. 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U S Marine Hospital Wyman Park Drive & 31st St., Balto, 11, Md

C. Length of stay in Baltimore: Yrs. — Mos. — Days: 1 day

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Virginia
B. COUNTY: --
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burgess Store
D. STREET ADDRESS (If rural, give location): --

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 8, 1902

9. AGE (In years last birthday): 47 — If Under 1 Year: Months / Days — If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ring-setter

10B. KIND OF BUSINESS OR INDUSTRY: Seaman

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Taylor

14. MOTHER'S MAIDEN NAME: Lucy Washington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO: 230-12-3459

17. INFORMANT: Record Room — ADDRESS: U S Marine Hospital, Baltimore, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis right and Cerebral Embolus left circumflex arteries.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio Vascular Disease

DUE TO

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

(over)

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 13, 1949, *to* Dec. 14, 1949 *that I last saw the deceased alive on* Dec. 14, 1949, *and that death occurred at* 9:38 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: William Cornwell M. D.

23B. ADDRESS: U S Marine Hospital Baltimore 11, Maryland

23C. DATE SIGNED: 12/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-18-49

24C. NAME OF CEMETERY OR CREMATORY: Lillian Fy.

24D. LOCATION (City, town, or county) (State): Va

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George D. Kelson — ADDRESS: 1303 Presstman st

931

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80885

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. | 93 | Registered No. C80885

1. NAME OF DECEASED (Type or Print) **Lutie Maitland Henderson**

2. DATE OF DEATH **Dec.14/49**

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **3720 Gwynn Oak Ave.**

c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland**
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore,**
D. STREET ADDRESS (If rural, give location) **3720 Gwynn Oak Ave.**

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| **Female** | **White** | **Married** | **Aug. 8, 1891** | **58** | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) **Md.**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Keller**

14. MOTHER'S MAIDEN NAME **Unknown**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT **George J. Henderson,** ADDRESS **3720 Gwynn Oak Ave.**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) **Glioma (Brain)** | **Oct 10 1949** |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION **Nov 30 1949**

19B. MAJOR FINDINGS OF OPERATION **Glioma - op. by D. Frank Otenasek**

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* **Oct. 10** *, 19* **49** *, to* **Dec 14** *, 19* **49** *, that I last saw the deceased alive on* **Dec 14** *, 19* **49** *, and that death occurred at* **10.7** A. m., *from the causes and on the date stated above.*

23A. SIGNATURE **Alan D Bubert** M. D.

23B. ADDRESS **4803 Park Heights Ave**

23C. DATE SIGNED **12/15/49**

24A. BURIAL, CREMATION, REMOVAL (Specify) **Burial**

24B. DATE **12/17/49**

24C. NAME OF CEMETERY OR CREMATORY **Woodlawn**

24D. LOCATION (City, town, or county) (State) **Woodlawn, Md.**

DATE RECEIVED BY LOCAL REGISTRAR **DEC 16 1949**

REGISTRAR'S SIGNATURE **Huntington Williams, M.D.**

25. FUNERAL DIRECTOR **Harry A. Wintse**

ADDRESS **4101 Edmondson Ave.**

VS 150

54a

G80836

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 420

G80836

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles J. Schramm

2. DATE OF DEATH Dec. 14/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 611 Lyndhurst St.

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a STATE Maryland
b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d STREET ADDRESS (If rural, give location) 611 Lyndhurst St. 16 - 5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | May 11, 1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ------Schramm | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Mary Anna Schramm | 611 Lyndhurst |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) arteriosclerotic heart disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Senile arteriosclerosis

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 2-9-49 *to* 12-14-49 *, that I last saw the deceased alive on* 12-12-49 *, and that death occurred at* 1450 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry S. Zimpel M. D. | 2203 Edmondson Ave | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Prospect Hill | Towson, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Harry F. Dinkle | 4101 Edmondson Ave. |

VS 150

937

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80887 ✓ X C80887

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

99-1 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louise Heidelbach

2. DATE OF DEATH: Dec 15, 1949

3. PLACE OF DEATH
a. Baltimore City, Maryland ✓

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md.
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Catonsville
d. STREET ADDRESS (If rural, give location): Bloomsbury Ave.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. ___ Mos. ___ Days ___

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | White | married | 7-8-1886 | 63 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | md. | |

13. FATHER'S NAME: George BALL

14. MOTHER'S MAIDEN NAME: Rebecca Umbaugh

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | George C. Heidelbach |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) MESENTERIC THROMBOSIS DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(b) GENERALIZED ABDOMINAL CARCINOMATOSIS DUE TO

(c) HYPERTENSIVE CARDIO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

VASCULAR DISEASE

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/11, 1949 *to* 12/15, 1949 *that I last saw the deceased alive on* 12/15, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| John H. Sharp M.D. | St. Agnes Hosp | 12/16/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 17/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Easton Sons Catonsville, Md. |

VS 150

55E

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80838

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80838

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EDWARD H. WEBER

2. DATE OF DEATH December 14, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 2022 E. Fayette Street 6 04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Divorced | Dec 27 1899 | 49 (mo) | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Drug Store | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harry E Weber | Lulu Mabrey |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 218-10-8172 | Lulu Weber | 2022 E Fayette St |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute pulmonary edema — DUE TO

ANTECEDENT CAUSES

(B) Myocardial hypertrophy and dilatation — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Syphilitic aortitis

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22 *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George L. Merrill M.D. | | Dec. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Mt Carmel | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, MD | Wilson & Col | 1214 Fond St |

30 D

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80883

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80883

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AGNES V. SHEETS

2. DATE OF DEATH: Dec. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3520 N. Hilton St.
C. Length of stay in Baltimore: Shriner's Nursing Home — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1030 N. Gay St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Feb. 1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At. Home | Baltimore, Md. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mary Soper

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Pearl Rohner | Middle River, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH. (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute dilatation of heart — Interval between onset and death: 3 days.

DUE TO

(B) Cardio Vascular Disease — 2.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/9th, 1949 *to* Dec 12th, 1949 *that I last saw the deceased alive on* 12/14th, 1949 *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. J. Faulker M. D. | 100 N. Milton Ave | 12/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

937

G80890

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80890

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CORA D. WOODALL

2. DATE OF DEATH: Dec. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2642 Maryland Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2642 Maryland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Aug. 30, 1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At. Home | Baltimore, Md. | |

13. FATHER'S NAME: Theodore Lerp

14. MOTHER'S MAIDEN NAME: Kathryn Hinkle

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | James Woodall | 2642 Maryland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senile degeneration — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

(B) Hypostatic pneumonia & Apoplexy — 4 days

DUE TO

Paralysis with Cardiac insufficiency — 24 hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 11, 1949 *to* Dec 14, 1949 *that I last saw the deceased alive on* Dec 14, 1949 *and that death occurred at* 4:05 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rogers E. Brosnan M. D. | 2038 Maryland Ave | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Mt. Olivet Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

830

G80891 ✓ G80891

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4th D. 1

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELLA M. REID

2. DATE OF DEATH Dec 13, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3154 Kesmick Rd.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 3154 Kesmick Rd. 13 - 5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | March 22 1887 | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Dupont Co | Md. | |

13. FATHER'S NAME Adam L. Barnes.

14. MOTHER'S MAIDEN NAME Katherine Hawthorn.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | 219-20-8949 | Katherine Black | 1241 W 32nd St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — Dec 5/49

DUE TO

(B) Coronary Heart Disease — 3 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug 3, 19[illegible] *to* Dec 13, 1949, *that I last saw the deceased alive on* Dec 13, 19 49 *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L. Williams M. D. | 878 W 36th St | Dec 14 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | London Park | Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Paul E. Schenning Jr. | 3405 Edmondson Ave |

VS 150

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80892

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

81.0

G80892

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Frank George Lotterweich

2. DATE OF DEATH: December 11, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3203 E. Monument Street 26 10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | 8-14-1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Office Clerk | Baltimore City | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: John J. Dotterweich

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | ? | John J. Dotterweich | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Ruptured esophageal varices, portal cirrhosis of liver

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Papillary adenocarcinoma of the kidney with metastases.

INTERVAL BETWEEN ONSET AND DEATH

over

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* September 7, 1949 *to* December 11, 1949, *that I last saw the deceased alive on* Dec. 11, 1949, *and that death occurred at* 8:45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Sliwinski, M. D. | St. Joseph's Hosp. | 12/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-17-49 | OAK LAWN | BALTO. CO. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Covington Williams, M.D. | WILLY & GEILER INC. | BALTO. |

VS 150

124a 52a

C80893

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80893

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BRAJKOVIC, MIHO

2. DATE OF DEATH: Dec. 14, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U S Marine Hospital Wyman Park Drive & 31st St., Baltimore, 11, Md
c. Length of stay in Baltimore: Yrs. 112 days, Mos., Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Philadelphia
D. STREET ADDRESS (If rural, give location): 709 S. 3rd St., Philadelphia, Pa

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | (Separated) Married | Sep 9, 1902 | 47 46 | 2 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AB Seaman | Seafarer | Yugoslavia | |

13. FATHER'S NAME: Antone Brajkovic

14. MOTHER'S MAIDEN NAME: Martia (?)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Unknown | | 095-12-4852 | Record Room, U S Marine Hospital, | Baltimore 11, Maryland |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pneumonia, lobular — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of the tail of the pancreas with metastasis to stomach, serosa of colon, lungs and liver — Unknown

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* Aug. 24, 1949 *to* Dec. 14, 1949, *that I last saw the deceased alive on* Dec. 14, 1949, *and that death occurred at* 1:20 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. W. PATRICK, Medical Director, M.D. | U S Marine Hospital Baltimore 11, Maryland | Dec. 15, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Mount Carmel | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Willy & Weiler Inc. | Balto. |

VS 150

469

G80894

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80894

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Vatch Wm. Simpson — Vatch William Simpson
2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY: Howard; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ellicott City; D. STREET ADDRESS (If rural, give location): Forrest St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Single | 2-22-1912 | 37 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Ellicott City, Md | |

13. FATHER'S NAME: Vatch Simpson
14. MOTHER'S MAIDEN NAME: Mary Jensen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Charles Redmond, Ellicott City, Md. — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Renal insufficiency | Undet. |
| DUE TO (B) | Chronic glomerulonephritis | Undet. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Congestive Heart Failure | Undet. |

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐: 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8-49 19__ *to* 12-14 19__ *that I last saw the deceased alive on* 12-13 19 49 *and that death occurred at* 1 20 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Lucian W. Leape, M.D. — 23B. ADDRESS: President Hosp. — 23C. DATE SIGNED: Dec. 14, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 12-18-49 — 24C. NAME OF CEMETERY OR CREMATORY: Western Star — 24D. LOCATION (City, town, or county) (State): Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949 — REGISTRAR'S SIGNATURE: Huntington Williams, M.D. — 25. FUNERAL DIRECTOR — ADDRESS: F. C. Higinbothom, Ellicott City, Md.

VS 150

correct age is especially important. Physicians: please write the name of death clearly and legibly.

1318

G80895 ✓X G80895

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH 331

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELLA MAE BEASLEY

2. DATE OF DEATH: 12-13-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bengies Md
D. STREET ADDRESS (If rural, give location): Eastern Ave Bengies Md.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colour | married | Feb 10, 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Balto. Md. | |

13. FATHER'S NAME: Samuel Owings

14. MOTHER'S MAIDEN NAME: Maggie Owings

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Louis Beasley. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Essential Hepertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-13, 1949 *to* 12-13, 1949 *that I last saw the deceased alive on* 12-13, 1949 *and that death occurred at* 6.15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kaan M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 8/49 | Sharp St Cem | Chase Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 16 1949 | Huntington Williams M.D. | Mrs Robert G. Elliott & Dtr 83a 1297 N. Carolina St |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80896

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450.0

G80896

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): PHILLIPP BOENNING

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 900 S. Baylis St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 900 S. Baylis St. 26 - 9

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Sept. 12, 1856 | 93 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Shoe maker- retired | Shoe | Germany | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Carl J. Boenning | 717 S. Potomac St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility —

DUE TO

(B) Generalized arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/10, 19 49, to 12/15, 19 49, *that I last saw the deceased alive on* 12/14, 19 49, *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. Theo F. Kenderdine M. D. | 1016 E. East Ave | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Western | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Ullrich Funeral Home | 2008 Orleans St., |

VS 150

97

G80897

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

54

G80897

BIRTH NO

Registered No.

1. NAME OF DECEASED (Type or Print) MRS. AGNES KEEFER HILL

2. DATE OF DEATH Dec. 15, '49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital
c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1501 Park Ave. 14-C

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | W | Apr. 3, 1876 | 73 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | MARYLAND | U.S.A. |

13. FATHER'S NAME Henry J. Krise

14. MOTHER'S MAIDEN NAME Sara P. Keefer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT Mr. Harry E. Krise ADDRESS 1501 Park Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gangrene of descending colon — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(B) Mesenteric arterial occlusion — 5 days
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(1) Intestinal obstruction — (1.) 10 days
(2) Carcinoma of rectum — (2.) 10 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Dec 10 1949 | Intestinal obstruction, Rectal tumor | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 8, 1949 *to* Dec 15, 1949 *that I last saw the deceased alive on* Dec 15, 1949, *and that death occurred at* 11:15 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lee M. Howard M. D. | Church Home and Hospital | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/17/49 | Greenhill Cem. | Martinsburg, W. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

46D

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 12-22-49 ✓

G80898 G80898

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

180 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY MARGARET LAIDLAW

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3602 Mohawk Ave.
c. Length of stay in Baltimore: 8 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3602 Mohawk Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | married | Jan. 27, 1888 | 61 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Bedark, Novia Scotia, Canada | |

13. FATHER'S NAME: William ~~Alexander~~ Taylor

14. MOTHER'S MAIDEN NAME: Morrison Sarah MacLean

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Donald H. Laidlaw | 3602 Mohawk Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Kidney — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-1-, 19[illegible] *to* 12-15-, 19[illegible] *that I last saw the deceased alive on* 12-15-, 19[illegible], *and that death occurred at* 5:5 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul E Carliner M. D. | 2217 [illegible] | 12/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Woodlawn Cem. | Everet, Mass. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

52a

G80893

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. G80893

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James C. Leib (Leibs)

2. DATE OF DEATH: 12/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital
C. Length of stay in Baltimore: Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 101 W. 39th St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | M. | Oct 20, 1864 | 85 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst Supt Balto G.S.L. Co
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Laib
14. MOTHER'S MAIDEN NAME: Margaret Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Margaret L. Matthews — ADDRESS: 6 E. Read St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic C. V. Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. J. Lubrano M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12/17/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 16/49 | Druid Ridge Cemy. | Pikesville Balto. Co. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: John D. Mitchell Sons 1400 Eastern Ave

VS 151

93D

C80900

BALTIMORE CITY HEALTH DEPARTMENT, 19 49

# CERTIFICATE OF DEATH

Registered No. C80900

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dr. Thomas S. Brown

2. DATE OF DEATH: Dec. 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2408 Overland Ave.
C. Length of stay in Baltimore: 28 years. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-03
D. STREET ADDRESS (If rural, give location): 2408 Overland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | June 13, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Professor | Social science | Jamaica B. W. I. | U. S. A. |

13. FATHER'S NAME: Thomas Brown

14. MOTHER'S MAIDEN NAME: Diane Williams

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Lillian C. A. Brown | 2408 Overland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinomatosis | 3 months |
| DUE TO (B) | Carcinoma of Prostate | 6 months |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 19 49 *to* Dec 15, 19 49 *that I last saw the deceased alive on* Dec 15, 19 49, *and that death occurred at* 3:40 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Rodman Higgins M. D. | 2340 Madison Ave | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Dec. 17, 1949 | Loudon Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| ~~DEC 16 1949~~ | Turrington Williams M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

VS 150

51B

Correct ages if especially important. Physicians: please write the cause of death plainly. Avoid abbreviations.

C80901

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 44

C80901 Registered No.

1. NAME OF DECEASED (Type or Print): ALBERT RICE

2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: 54 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE -17
D. STREET ADDRESS (If rural, give location): 1805 MADISON AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | W | Feb. 22, 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| LABORER | Roofing company | MD. | U.S.A. |

13. FATHER'S NAME: THOMAS RICE

14. MOTHER'S MAIDEN NAME: GEORGIANNA WILLIS

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| UNKNOWN | 216-03-7122 | PATIENT | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage,

DUE TO

(B) Hypertensive C.V. Disease

DUE TO AND

(C) NEPHROSCLEROSIS & NECROSIS (ANURIA)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 12-11 1949 to 12-14 1949, *that I last saw the deceased alive on* 12-14 1949, *and that death occurred at* 7:05 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. G. Rewbenick Jr. M.D. | University Hospital | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 17, 1949 | Mt. Auburn | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Evelyn Williams, M.D. | Holland Funeral Home | 1601 Druid Hill Ave |

VS 150

12/a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80902

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80902

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FREDERICK LOOSE SR.

2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1339 Hull St
C. Length of stay in Baltimore: 61 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1339 HULL

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: 1-11-1888
9. AGE (In years last birthday): 61
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STEVEDORE
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): BALTIMORE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: AUGUST LOOSE
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: 215-01-4846
17. INFORMANT: John G. Loose ADDRESS: 1339 Hull St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. — 1949 to Dec 15, 1949, that I last saw the deceased alive on 12/14/1949, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Walter Cohn M.D. M.D.
23B. ADDRESS: 1 E. Fort Ave
23C. DATE SIGNED: 12/15/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-17-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem
24D. LOCATION (City, town, or county) (State): Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles F. Dill ADDRESS: 1501 E. Fort Ave

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80903

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80903

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Ann Jones

2. DATE OF DEATH: Dec 15 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 302 E. Gittings Ave

c. Length of stay in Baltimore: 50 Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-12
D. STREET ADDRESS (If rural, give location): 302 E Gittings ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W | married | Feb 1 1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Haverhill Mass | |

13. FATHER'S NAME: Michael Condon McNamara

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Carroll

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Arthur Carroll Jones (Same) | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis - generalized — years.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* January, 1949 *to* Dec. 15, 1949 *that I last saw the deceased alive on* Dec. 15, 1949, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry M. Hower M. D. | 207 Preston Street | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 18 1949 | Prospect Hill | Towson Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Henry W. Jenkins & Sons Co | 4925 York Rd. |

VS 150

937

C80904

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 981. Registered No. C80904

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM LAYTON — N-863.4

2. DATE OF DEATH December 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore.
D. STREET ADDRESS (If rural, give location) 202 N. Fremont Avenue 1 F C

5. SEX M
6. COLOR OR RACE C
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH July 12, 1931
9. AGE (In years last birthday) 18 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Stephen Layton
14. MOTHER'S MAIDEN NAME Hattie ? Kelley.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Hattie Layton. ADDRESS 202 N. Fremont Ave,

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gunshot injury of abdomen
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Penna. Ave. & Hoffman St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) December 12, 1949 10:15 p. m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK X
21F. HOW DID INJURY OCCUR? Homicide

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, *Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide X, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER X ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED December 13, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-16-1949
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem
24D. LOCATION (City, town, or county — State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 16 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Katie R. Williams & Schroeder
ADDRESS 322 N

VS 151

166

Direct age is especially important. Physician: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 12-20-49

G80905

JL 134162

BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80905

1. NAME OF DECEASED (Type or Print): Joseph Derecki

2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals

c. Length of stay in Baltimore: 62 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 521 S. Curley St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | White | Wid. | Mar. 10, 1871 | 78 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Iron Molder | Foundry | Poland | U.S.A. |

13. FATHER'S NAME: William Derecki

14. MOTHER'S MAIDEN NAME: Agnes ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | B. C. H. Records, 4940 Eastern Ave. |

MEDICAL CERTIFICATION

16. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary Tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Uremia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 12 1949, *to* Dec. 14, 1949, *that I last saw the deceased alive on* Dec. 14, 1949, *and that death occurred at* 6.20pm, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 4940 Eastern Ave. | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Polish National Catholic | German Hill Rd Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | [signature] | Mildred I. Blight | 6009 Harford Rd |

VS 150

136

Correct age if "specialty" important. Physicians: please write the cause of death clearly and legibly.

G80906 ✓ G80906

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY MARKERT

2. DATE OF DEATH: Dec. 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3112 Rosekemp Ave.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3112 Rosekemp Avenue

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Feb. 4, 1866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Baltimore, Md. | U.S. |

13. FATHER'S NAME: John Kram

14. MOTHER'S MAIDEN NAME: Wilhelmina

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Wilhelmina Hopp, 2711 E. Monument St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial degeneration & arterial changes

DUE TO

(B) Confined to bed since R. hip fracture — Feb 1948.

DUE TO

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Fracture Ununited R hip 12 mos ago

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident | home | Baltimore Md |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Feby 1948 a. m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | fell as she started for front door. |

22. I hereby certify that I attended the deceased from Feby 7, 1948, to Dec 13, 1949, that I last saw the deceased alive on Dec 13, 1949, and that death occurred at 4:50 P. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John W. C. Clift M. D. | 5076 Greenleaf Road | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Holy Redeemer Cem. | 4430 Belair Rd. Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 150

937

Correct Age if Especially Important — Physicians: please write the cause of death clearly and legibly.

C80907

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 890.0

C80907 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES C. POPP N-968

2. DATE OF DEATH: December 13, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital

C. Length of stay in Baltimore: 66 Years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2013 W. Lanvale Street 16-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Seperated | June 17th, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | Painting | Baltimore Md. | U.S. |

13. FATHER'S NAME: Conrad Popp

14. MOTHER'S MAIDEN NAME: Catherine Wertz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218-03-0165

17. INFORMANT: Mrs. Mamie Proctor ADDRESS: 2013 W. Lanvale St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon monoxide poisoning.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2013 W. Lanvale Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 12, 1949 ?P. m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Chimney blocked--would not draw

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George G. Merrill M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 12-14-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/16/49 | Mount Olivet Cemetery | Baltimore Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Geo. L. Boyd Jr. ADDRESS: 1512 Hollins St. Balto. 23 Md.

Mt Olivet 178c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

C80908

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C80908

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Lottie M. Malone

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Fayette & Payson St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

c. Length of stay in Baltimore: 63 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2016 Pennsylvania ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Sept. 17-1896 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at Home | Baltimore Md | U.S. |

13. FATHER'S NAME: John Beahtold

14. MOTHER'S MAIDEN NAME: Mary Bendorf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: ~

17. INFORMANT: Mrs. Claudia C. Young — ADDRESS: 2016 Pennsylvania ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Covanary Artery Occlusion

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 15, 1949 *to* Dec. 15, 1949 *that I last saw the deceased alive on* Dec. 15, 1949, *and that death occurred at* 3.05 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. J. Mahler, M. D.

23B. ADDRESS: Bon Secours Hosp.

23C. DATE SIGNED: 12/15/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Western Cemetery | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Geo. K. Bayer Jr — ADDRESS: 1512 Hollins St Balto 23 Md

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

94a

CERTIFICATE CORRECTED 12-[illegible]

C80909 C80909

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William F. Maule

2. DATE OF DEATH 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY General Hospital
C. CITY OR TOWN (If outside corporate limits write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1108 East 20th Street # 18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Aug. 27, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Grocer | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Conrad Maule | Rebecca Groseck Grover |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | wife Mildred | as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tracheobronchitis acute ① due to emphysema ② due to left lung — INTERVAL BETWEEN ONSET AND DEATH: several days

(B) Bronchial asthma compensatory ② due to Pneumonectomy right — see below

(C) Bronchogenic carcinoma Rt ③ liver metastasis main stem bronchus — unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Heart Disease Calcific Aortitis Carcinoma Bronchiogenic

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 9-6-49 | Pneumonectomy right | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8-25-49 – 10-2-49 and 10-19-49 – 10-29-49 *to* 12-14, 1949 *that I last saw the deceased alive on* 12/14, 1949, *and that death occurred at* 1205 p m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marguerite Louise Caudle M.D. | Maryland General Hospital | 12-14-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC. 17-1949 | ST. JOHNS EVANGELICAL LUTHERN CHURCH CEMETERY | PARKVILLE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Contractor Williams, M.D. | Chas. E. Evans & Son, Inc. | 118 N. Mt. Royal Ave. Balto. Md. |

VS 150

1st Admission 8-25-49 — 10-2-49
2nd Admission 10-19-49 — 10-29-49
3rd Admission Jan 13-49 — 12-14-49

47c

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80910 BALTIMORE CITY HEALTH DEPARTMENT C80910

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD M. CLINE

2. DATE OF DEATH: 12/14/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1729 Thomas avenue
c. Length of stay in Baltimore: 9 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1729 Thomas avenue

5. SEX: Male
6. COLOR OR RACE: white
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): Married
8. DATE OF BIRTH: 8/26, 1910
9. AGE (In years last birthday): 39
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipping clerk
10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Matthew Cline
14. MOTHER'S MAIDEN NAME: Josephone Mary Healy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): World War #2
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Mary Hunley Cline ADDRESS: 1729 Thomas Avenue

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | acute. |
| DUE TO (B) | | attack July 15 '48 |
| ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT SUICIDE HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* July 15 1948 *to* Dec. 14 1949, *that I last saw the deceased alive on* Dec 14, 1949, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. E. Needle M. D.
23B. ADDRESS: 314 W. Nan Dr
23C. DATE SIGNED: 12/16/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/19/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore National
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas. L. Evans & Son Inc.
ADDRESS: 118 W. Mt. Royal ave. Balto.

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80911 ✓ C80911

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 416

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Mamie (Mary) Jurkowski | 2. DATE OF DEATH: Dec. 14, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY: |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3112 E. Monument St. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore |
| c. Length of stay in Baltimore: Yrs. Mos. Days | D. STREET ADDRESS (If rural, give location): 3112 E. Monument St. 2-01 |
| 5. SEX: female | 6. COLOR OR RACE: white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: Nov. 1, 1895 |
| 9. AGE (In years last birthday): 54 | If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife | 10B. KIND OF BUSINESS OR INDUSTRY: |
| 11. BIRTHPLACE (State or foreign country): Baltimore | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: William Prechtel | 14. MOTHER'S MAIDEN NAME: not known |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
| 17. INFORMANT: Dorothy Kraft | ADDRESS: 3112 E. Monument St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial failure | 1 week |
| DUE TO (B) | Rheumatic Heart Disease | 30 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* May, 1946, *to* Dec., 1949, *that I last saw the deceased alive on* Dec. 13, 1949, *and that death occurred at* 4:25 A. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE: Clarence W. LeGoys, M. D. | 23B. ADDRESS: 3023 Eastern Ave | 23C. DATE SIGNED: 12/15/49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 12/17/49 | 24C. NAME OF CEMETERY OR CREMATORY: Baltimore |
| 24D. LOCATION (City, town, or county) (State): North Ave & Rose St. | | |
| DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Clarence F. Hoffmann ADDRESS: 1639 Broadway. |

VS 150

951B

Correct age is especially important. Physicians please write the causes of death clearly and legibly.

B-133640

G80912

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

63

G80912

Registered No.

1. NAME OF DECEASED (Type or Print): William E. Leizear

2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 229 S. Broadway zone 31

5. SEX: Male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Oct. 29- 1895
9. AGE (In years last birthday): 54 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur
10B. KIND OF BUSINESS OR INDUSTRY: Diamond Cab Co
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Emmit Leizear — Deceased
14. MOTHER'S MAIDEN NAME: Mary ? — Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 217-07-7813
17. INFORMANT: Baltimore City Hospitals Records: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute dilatation of Heart
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Attempted Left Pneumonectomy
DUE TO

(C) Carcinoma of Left Lung

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 12-14-1949
19B. MAJOR FINDINGS OF OPERATION: Pneumonectomy-Unfinished
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-21- , 1949, *to* 12-14- , 1949, *that I last saw the deceased alive on* 12-14- , 1949, *and that death occurred at* 12.05 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Baltimore City Hospitals
23C. DATE SIGNED: 12-16-1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 16 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
24D. LOCATION (City, town, or county) (State): O'Donnell St Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: [signature] Huntington Maryland, Md
25. FUNERAL DIRECTOR: Duffy Bros. ADDRESS: 1800E Lombard St

To Be Approved By The Medical Examiner

47D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr. Harbold C80913

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C80913 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lelia L. Wood

2. DATE OF DEATH: Dec. 14. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4506 Weitzel Avenue

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4506 Weitzel Avenue

| 5. SEX | 6. COLOR or RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | married | Apr. 1, 1879 | 70 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at home | | Parisburg, Virginia | |

13. FATHER'S NAME: John Stockton

14 MOTHER'S MAIDEN NAME: Georgia Woodrum

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mr. Frank W. WOOD, | 4506 Weltzel Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of breast

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Metastasis to lungs — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Parkinsonism (severe)

INTERVAL BETWEEN ONSET AND DEATH: 4½ yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 14, 1949 *to* Dec 14, 1949 *that I last saw the deceased alive on* Dec 13, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. F. Harbold M. D. | 4706 Harford Road | Dec 16, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-17-49 | Moreland Park | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Functioning for Williams M.D. | Leonard J. Ruck | 5305 Harford Road |

50

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80914

BIRTH NO. 49-21771

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80914

1. NAME OF DECEASED (Type or Print): ETHEL MADELINE MILLER

2. DATE OF DEATH: 12-15-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3807 FOURTH AVE.

c. Length of stay in Baltimore: Yrs. WIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 3807 FOURTH AVE.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | SINGLE | 9-9-1949 | | 3 / 6 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | NONE | MD. | U.S.A. |

13. FATHER'S NAME: PATRICK J. MILLER

14. MOTHER'S MAIDEN NAME: ETHEL HENDERSON

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NONE | NONE | ETHEL MILLER | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) pneumonia (virus)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/13, 1949 *to* 12-15, 1949 *that I last saw the deceased alive on* 12/14, 1949, *and that death occurred at* 5 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles W Kreeter M. D. | 302 Patapsco Ave | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12/17/49 | MT. CARMEL | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | Lilly & Feiler Inc. | Balto. Md. |

VS 150

109a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80915

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 97 1-8

C80915
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Dewey Percy N-979.

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1714 Bolton St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1714 Bolton St. 14-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | divorced | Feb. 22, 1898 | 51 yrs. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bar Tender (rtd)
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cambridge, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph B. Percy
14. MOTHER'S MAIDEN NAME: Mary V. Furley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 198-05-3898
17. INFORMANT: Miss Cora V. Percy ADDRESS: 1714 Bolton St.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cyanide poisoning
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1714 Bolton St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 15, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Ingestion of cyanide

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Russell S. Fraser M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec. 16, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Woodlawn Cem. | Woodlawn, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 151

1639

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80916 — BALTIMORE CITY HEALTH DEPARTMENT — G80916

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): ROBERT BERTRAND WATERS — 2. DATE OF DEATH: December 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Stoney Beach Baltimore 26 Md
D. STREET ADDRESS (If rural, give location): 1260 Beach Promenade

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 5-23-1933 | 16 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Labor | Maryland Biscuit Co | Maryland | |

13. FATHER'S NAME: Elmer J. Bertrand
14. MOTHER'S MAIDEN NAME: Hilda Kelly

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 212-30-6870 | Mrs Hilda Waters | above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Contusion of brain.
DUE TO
(B) Traumatic hemorrhages of brain.
DUE TO
(C) Terminal bronchopneumonia.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Road | Ft. Smallwood Rd. 500' N. of Duvall H'way |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 4, 1949 12:35A m. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Auto into tree. |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | [X] | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-19-49 | Oaklawn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Huntington Williams, M.D. | John A. Moran | 3000 E. Balt. St. |

VS 151

170C

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80917 ✓ G80917

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 443

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Stricker

2. DATE OF DEATH: Dec 14 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 1719 Lemmon st

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md COUNTY Balt

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1719 Lemmon st

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-04

c. Length of stay in Baltimore: Life Yrs. Mos. Days

d. STREET ADDRESS (If rural, give location): 1719 Lemmon st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Jan 15 1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hostler Retired

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph Stricker

14. MOTHER'S MAIDEN NAME: Sarah —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Howard Stricker ADDRESS: 2611 Hope

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wk.

DUE TO

(B) Hypertensive Cardio-Vasc Disease — 4 yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-23, 1949 *to* 12-14, 1949, *that I last saw the deceased alive on* 12-13, 1949, *and that death occurred at* 12:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nelson K. Gallagher M.D. M. D. | Catonsville 28, Md. | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-17-49 | Westlawn | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George A Farley ADDRESS: Fulton & Fayette

VS 150

937

G80918

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163

G80918

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) Rosalie Morozzi

2. DATE OF DEATH 12/16/49

3. PLACE OF DEATH: Baltimore City, Maryland Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE W. Va
B. COUNTY 2
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarksburg
D. STREET ADDRESS (If rural, give location) Route #3 Box 61

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore one week (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | June 3, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Italy | U.S.A. |

13. FATHER'S NAME Joseph Manloni

14. MOTHER'S MAIDEN NAME —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Patsy Morozzi - Husband ADDRESS Clarksburg, W. Va. Route #3 Box 61

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma of Lung | years |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12/14/49 | Carcinoma of left lung | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/14/49, 19__, *to* 12/16/49, 19__, *that I last saw the deceased alive on* 12/16 19__, *and that death occurred at* 5:16 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard Raskin M. D. | Mercy Hospital | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Clarksburg | Clarksburg, W. Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Thurlington Williams, MD | H. H. Means & Son | 105 N. Calhoun St |

VS 150

47)

Agent age is especially important. Physician: please write the cause of death clearly and legibly.

G80913

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43 G80913 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Loretta Warren

2. DATE OF DEATH 12-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 25-43
D. STREET ADDRESS (If rural, give location) 2224 Wash Blvd.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | M | June 188? | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| H.F | Housewife | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? | ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | E. J. Warren | 2224 Wash Blvd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Left Cerebral Hemorrhage
DUE TO Rupture into lateral ventricle
(B) Generalized Arteriosclerosis
DUE TO Hypertension & Arteriosclerotic
(C) C.V.D.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 6 1949 *to* Dec 16 1949, *that I last saw the deceased alive on* 12-16 1949, *and that death occurred at* 12 40 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Kale G. Swinley Jr. M. D. | Univ. Hosp. | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | | Bridgeport Conn |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 16 1949 | Courtesy for Williams, Mgr | Edward Fowlson | 2355 Wash Blvd |

VS 150

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

GM 137868

G80920

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

290.1 G80920

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Laura Temperence Bell

2. DATE OF DEATH: 12- 16- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: 14 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 23-02
D. STREET ADDRESS (If rural, give location): 1526 Light ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | July 30 1893 | 56 Yrs. | 4 | 16 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | PA. | |

13. FATHER'S NAME: William Rash ( D )

14. MOTHER'S MAIDEN NAME: Angeline Mann ( D )

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | Records B.C.H. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Malnutrition

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Degenerative Cord Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12- 1- , 1949, *to* 12- 16- , 19 49 *that I last saw the deceased alive on* 12- 16- 1949 , *and that death occurred at* 8. 10 AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | B.C.H. 4940 Eastern Ave. | 12- 16- 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 19 1949 | Rose Hill | Hagerstown, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | C. M. Suter and Son. | Hagerstown |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

82

C80921 ✓ 50.0 C80921

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH JANE BENNETT

2. DATE OF DEATH: 12-13-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 328 East Lafayette Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 12-05
D. STREET ADDRESS (If rural, give location): 328 E. Lafayette Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | widowed | 1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at Home | - | Ireland | |

13. FATHER'S NAME: Edward Bennett

14. MOTHER'S MAIDEN NAME: CATHERINE FOX.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | - | - |

17. INFORMANT: 328 E. Lafayette Ave. Miss Katherine Bennett

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Insufficiency | 1 Week |
| DUE TO (B) | Generalized Arteriosclerosis | 2 Years |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 12, 1949, *to* Dec 13, 1949, *that I last saw the deceased alive on* Dec 13, 1949, *and that death occurred at* 11:50 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas F. White M. D. | 3809 Greenmount Ave | 12/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-17-49 | Cathedral Cem | City |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 16 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: WIEDEFELD AND SON

ADDRESS: GREENMOUNT AVE. & 22nd ST.

931

VS 150

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

BS-134240

G80922

# CERTIFICATE CORRECTED 12-19-49

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

4/16

G80922

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Irene Starka

2. DATE OF DEATH 12-15-49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 10-01
D. STREET ADDRESS (If rural, give location) 1232 Greenmount Avenue (2)

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals

c. Length of stay in Baltimore: Yrs. Life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Wid | Jan. 20, 1896 ~~Jan. 26, 1895~~ | 54 53 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Md | |

13. FATHER'S NAME (D) Harmaus Smith

14. MOTHER'S MAIDEN NAME (D) Annie Black

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Records*Balto. City Hospitals | 4940 Eastern Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Rheumatic Heart Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Pulmonary Infarction | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Congestive Heart Failure | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-15, 1949, *to* 12-15, 1949, *that I last saw the deceased alive on* 12-15, 1949 *and that death occurred at* 3:00 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. H. Thayer M. D. | 4940 Eastern Avenue | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Fairmount | Parkville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Penelope Williams, M.D. | Wilhom & Dad | 1219 Park Ave |

VS 150

To Be Approved by The Medical Examiner

(OVER)

9512

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(4)

680923 BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 903 0 680923 Registered No.

1. NAME OF DECEASED (Type or Print): August Reinle N-820.0

2. DATE OF DEATH: Dec 15, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: 29
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04
D. STREET ADDRESS (If rural, give location): 5101 Greenwich Ave

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Univ. Hosp.

c. Length of stay in Baltimore: Unknown. (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | 1859 | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | None | Maryland | USA |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | Unknown | Daughter | NYC, NY. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure due
DUE TO
(B) to pneumonia, just.
DUE TO
(C) morbis. CERTIFICATION APPROVED BY A. A. Merrill M. D.
CHIEF OR ASST. MEDICAL EXAMINER

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7 1/4 hrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Dec 6, 1949 | Fracture of neck of st. femur. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home. | 2 [illegible] Greenwich Avenue |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 24, 1949 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fell. to floor helping [illegible] |

22. I hereby certify that I attended the deceased from Dec 1, 1949 to Dec 15, 1949, that I last saw the deceased alive on Dec 11, 1949, and that death occurred at 12:40 P.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. A. Markham M.D. M. D. | Univ. Hosp. | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Forest Ridge | Pikesville, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Investigator Williams, M.D. | Harry H. Wintzfeldt | 4101 Edmondson Ave |

VS 150

186a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80924
B-134066

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH
Registered No. C80924

STATE FILE NO.

1. NAME OF DECEASED (Type or Print): Amelia Pauline Lacer (Locer)

2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 49 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 24-04
D. STREET ADDRESS (If rural, give location): 1736 Webster St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Mar. 31, 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home | New York | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Herman Albert | Margaret ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT (Name and address) |
|---|---|---|
| | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio vascular renal disease
DUE TO
(B) Uremia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

(over)

CERTIFICATION APPROVED BY
BY Robert B. McFadden per R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-11-49 | Biopsy uterus | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12-8- , 1949, *to* 12-15- , 1949, *that I last saw the deceased alive on* 12-15- , 1949, *and that death occurred at* 5:55 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. A. Dozier M. D. | B.C.H.--4940 Eastern Ave. | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/17/49 | Loudon Park | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | [illegible] | Jas. L. McCarthy | 130 E. Fort Ave. |

VS 150 To Be Approved By Chief Medical Examiner

1310

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80925 — 134143 — G80925

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

578 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Patsy Leveine Burrell

2. DATE OF DEATH: 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Dundalk
D. STREET ADDRESS (If rural, give location): 213 Fairbanks Ct-22

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | Negro | Single | June 16, 1949 | | 5 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Edmund Burrell

14. MOTHER'S MAIDEN NAME: Louise Allen

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | B. C. H. Records, 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intestinal perforation (over)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Malnutrition

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-14-49 | Tracheotomy | YES Yes NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 11, 1949 *, to* Dec. 14 *, 19* 49 *that I last saw the deceased alive on* Dec. 14 *, 19* 49 *and that death occurred at* 9PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. A. Mozen M. D. | 4940 Eastern Ave. | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-17-1949 | Mt. Auburn Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Justin for Williams, M.D. | Mrs Katie R. Williams Schroeder | 3228 |

VS 150

123

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80926

BALTIMORE CITY, HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

53

Registered No. G80926

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALVERDA VIRGINIA BUSCHMAN

2. DATE OF DEATH: Dec. 14th, 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto (Stoneleigh)
D. STREET ADDRESS (If rural, give location): 902 Old Oak Road, Balto 12, Md

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Married | 3-6-01 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | at home | Maryland. | |

13. FATHER'S NAME: Joshua G. Hipsley

14. MOTHER'S MAIDEN NAME: Alverda V. Woodward

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mr. George G. Buschman | 902 Old Oak Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis

DUE TO

(B) Carcinoma of Sigmoid Colon.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-21, 1949, *to* Dec. 14th, 1949, *that I last saw the deceased alive on* Dec. 14th, 1949, *and that death occurred at* 11.20 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. J. Castellano M. D. | Bon Secours Hospital | 12-14-1949. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/17/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Hunter for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80927 **CERTIFICATE CORRECTED** 12-28-49 ✓ X G80927

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

463 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edgar DICK

2. DATE OF DEATH: 12/17/49.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University of Md. Hospital.

c. Length of stay in Baltimore: Yrs. — Mos. — Days 7

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pennsylvania
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Delta
D STREET ADDRESS (If rural, give location):

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | — | 63. | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffeur | | Maryland | USA. |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| Wm. J. Dick | Ruth A. Moore. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs Anna Dick | same |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Massive Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(B) Thrombophlebitis, lower Ext, bilateral
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Uremia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/10, 1949, *to* 12/16, 1949, *that I last saw the deceased alive on* 12/16, 1949, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E Hall, Jr. M. D. | U of Md. Hospital | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Dec. 22, 1949 | Burial | Highland Presbyterian Cem. | Street, |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Tunis Augustus Williams, M.D. | | |

VS 150

100 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80928

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

17°

G80928

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mary Gertrude White

2. DATE OF DEATH: 12-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital
c. Length of stay in Baltimore: 5-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Dundalk)
D. STREET ADDRESS (If rural, give location): 7011 Dunmanway Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | married | May 30, 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | West Virginia | |

13. FATHER'S NAME: Harvey W. Fultz

14. MOTHER'S MAIDEN NAME: Alice Davidson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Percy A. White | 7011 Dunmanway Rd. |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Metastatic Breast Carcinoma
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 9-2, 1949 *to* 12-6, 1949, *that I last saw the deceased alive on* 12-6, 1949, *and that death occurred at* 6:50 pm, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kaan M. D. | St. Joseph Hospital | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-49 | Benedon | Bridgeport, W.Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Deputy for Williams, M.D. | G. Howard Strong | 3207 W. North Ave., |

VS 150

50

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

680923

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 1 Registered No. 680923

1. NAME OF DECEASED (Type or Print): Susie Jordan
2. DATE OF DEATH: Dec. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSP
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-94
D. STREET ADDRESS (If rural, give location): 2129 Walbrook Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | M. | 4-16-19 | 30 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Smith | Hattie Taylor |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Epidermoid Carcinomatosis. — INTERVAL BETWEEN ONSET AND DEATH: 1/2 years

DUE TO

(B) Epidermoid Carcinoma Cervix. — 2 years.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | Epidermoid Carcinoma Cervix. | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| | | | |

22. *I hereby certify that I attended the deceased from* 11/7, 1949, *to* 12/16, 1949, *that I last saw the deceased alive on* 12/16, 1949, *and that death occurred at* 8:20 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert P. Donnell M. D. | (JHHS) HOPKINS HOSP | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-49 | Lillian Jr | Jr |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Hunter Williams M.D. | George E. Pelson | 1303 Pratt Street |

VS 150

48a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80930
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 Registered No. G80930

1. NAME OF DECEASED (Type or Print): Mary Antionette Browne
2. DATE OF DEATH: Dec 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 15-01
D. STREET ADDRESS (If rural, give location): 1380 n. Carey st

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | M | Oct 31, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Wash. D.C. | |

13. FATHER'S NAME: Spencer Murray
14. MOTHER'S MAIDEN NAME: maggie myers

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Dr. Benjamin Browne | 1380 n. Carey st |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure
DUE TO Pul. Edema

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Cardio
DUE TO Sclerosis - Renal -

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12-5, 1949, to 12-15, 1949, that I last saw the deceased alive on 12-15, 1949, and that death occurred at 9:50 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. B. Butler M.D. | 703 E. 31st | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-19-49 | arbutus cem. | md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Thurlington Williams, M.D. | George L. Nelson | 1303 Presstmont |

VS 150

131a

Correct age is especially important — Payment of private duty nurse is a charge against the estate of deceased in this county

G80931

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G80931

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY Agnes McDONOUGH

2. DATE OF DEATH 12-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland BALTIMORE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2849 Chesterfield Ave

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 27-01
D. STREET ADDRESS (If rural, give location) 2849 CHESTERFIELD Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | | 59 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Wm. J. McDONOUGH
14. MOTHER'S MAIDEN NAME MARY A. McDONOUGH, OMALLEY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT John T. McDONOUGH ADDRESS 2849 Chesterfield Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Hypertension

DUE TO

(C) Arterio-Sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 14, 1949 *to* Dec 15, 1949 *that I last saw the deceased alive on* Dec 15, 1949 *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.
23B. ADDRESS 3805 Roland Ave.
23C. DATE SIGNED 12/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24B. DATE 12-19-49
24C. NAME OF CEMETERY OR CREMATORY New CATHEDRAL
24D. LOCATION (City, town, or county) BALTIMORE (State) Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 17 1949
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR John A. Moran ADDRESS 3000 E. Balto. St

VS 150

83a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

CERTIFICATE CORRECTED 3-B-50

G80932

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 32-1 Registered No. G80932

1. NAME OF DECEASED (Type or Print): John Jordan

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 28 Parken St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | ~~Single~~ Married | Dec. 3, ~~1912~~ 1913 | 36 ~~37~~ | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber
10B. KIND OF BUSINESS OR INDUSTRY: Williams Barber Shop
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Jordon
14. MOTHER'S MAIDEN NAME: Cora Prandenberg
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): W.W. 2
16. SOCIAL SECURITY NO.
17. INFORMANT: Cora Jordon ADDRESS: LaFolette, Tenn.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Fatty degeneration of liver | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Chronic Alcoholism | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: George G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Dec. 16, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/17/49
24C. NAME OF CEMETERY OR CREMATORY: LaFollette
24D. LOCATION (City, town, or county) (State): LaFollette, Tenn.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 17 1949
REGISTRAR'S SIGNATURE: Thurston for Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: William Cook, Inc., 1217 St. Paul St.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

124a

G80933

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 331

G80933 Registered No.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Alice Brooks Spilman
2. DATE OF DEATH: 12/15/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3208 Abell Avenue
C. Length of stay in Baltimore: 76 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): Baltimore, Md.
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3208 Abell Avenue 12-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | ------- | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | -------- | Baltimore, Md. | |

13. FATHER'S NAME: Robert L. Brooks
14. MOTHER'S MAIDEN NAME: Mary V. McMullan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mary V. Spilman 3208 Abell Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO: Hypertension & arteriosclerosis 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May, 1948 *to* Dec 15, 1949, *that I last saw the deceased alive on* Dec 15, 1949, *and that death occurred at* 4:40 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Franklin E. Leslie M. D. | 10 East Pratt St-Balto-2 | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Green Mount | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Huntington Williams, M.D. | H. W. Weaks and Son | 805 N. Calvert St. |

VS 150

83a

C80934 ✓ ✗ 4-20-1 C80934

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN N. Brewster

2. DATE OF DEATH December 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph's Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE New York
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New York
D. STREET ADDRESS (If rural, give location) 45 Christopher Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | | Dec. 21. 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bureau of Mines | Same | New York State | |

13. FATHER'S NAME: Charles H. Brewster

14. MOTHER'S MAIDEN NAME: Cora Puthill

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | H.P. O'Donnell | Washingtonville N.Y. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic cardiovascular disease with coronary thrombosis | 3 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Dec. 17, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 23.1949 | Washingtonville Cemy. | Washingtonville N.Y. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 17 1949 | Huntington Williams, M.D. | John O. Mitchell & Sons | 1900 Eutaw place |

John O. Mitchell 93 ✓

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

680935

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 680935

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JAMES M. DUFFY

2. DATE OF DEATH: Dec, 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 2824 N. Howard st.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 40 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 12-06
D. STREET ADDRESS (If rural, give location): 2824 N. Howard Street

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 12, 1876
9. AGE (In years last birthday): 73 — If under 1 year: Months 0, Days 5; If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. (Retired)
10B. KIND OF BUSINESS OR INDUSTRY: Construction Work
11. BIRTHPLACE (State or foreign country): Altoona, Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John Duffy
14. MOTHER'S MAIDEN NAME: Mary Feeney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Mrs. Mary R. Duffy — ADDRESS: 2824 N. Howard St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Coronary Thrombosis. | Several Hrs |
| DUE TO | | |
| (B) | Coronary Sclerosis. | Indefinite |
| DUE TO | | |
| (C) | Generalized Arteriosclerosis | Indefinite |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1945 *to* Dec 17, 1949 *that I last saw the deceased alive on* Dec 16, 1949 *and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Nathaniel M Beck M.D. M. D.
23B. ADDRESS: 1004, 23rd St Altoona
23C. DATE SIGNED: Dec 17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Dec.18,1949
24C. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
24D. LOCATION (City, town, or county) (State): Altoona, Penna.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 18 1949
REGISTRAR'S SIGNATURE: Dembrey to Hillmann, M.D.
25. FUNERAL DIRECTOR: William Cook, Inc. — ADDRESS: 1217 St. Paul Street

VS 150

94a

Cancel age is especially important. Physician should write out cause of death clearly and fully.

G80936

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80936
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Henry Jones

2. DATE OF DEATH: 12/10/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore, Md.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 321 N. Stricker St.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital

c. Length of stay in Baltimore: 10 yrs. (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Widower | Feb. 22/1871 | 78 yrs | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Jones
14. MOTHER'S MAIDEN NAME: Harriett Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Mrs. Beccie Harris — ADDRESS: 321 N. Stricker

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 16 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma of Cecum and ascending colon. — 3 months

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Dehydration

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 4, 19 49 *to* Dec 16, 19 49 *that I last saw the deceased alive on* Dec 16, 19 49, *and that death occurred at* 7 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Marcus W. Boone M. D.
23B. ADDRESS: President Hospital
23C. DATE SIGNED: 12/12/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-19-49
24C. NAME OF CEMETERY OR CREMATORY: Ebenezer Chapel
24D. LOCATION (City, town, or county) (State): Elkridge Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 14 1949
REGISTRAR'S SIGNATURE: Registrar for Baltimore, Md.
25. FUNERAL DIRECTOR: P. C. Hegenbothom — ADDRESS: Ellicott City

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

46E

BS-129308 G80937

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

010 G80937 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Willie Young

2. DATE OF DEATH: 12-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02

c. Length of stay in Baltimore: 5 Yrs. (Yrs. Mon. Days)

D. STREET ADDRESS (If rural, give location): 237 Myrtle Avenue (1)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | June 10, 1918 | 31 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | S.C. | |

13. FATHER'S NAME: Jim Young

14. MOTHER'S MAIDEN NAME: Ella Williams

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Records*Balto. City Hospitals | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Tuberculous Meningitis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5-30, 1949, *to* 12-16, 1949, *that I last saw the deceased alive on* 12-16, 1949, *and that death occurred at* 4:45 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 4940 Eastern Avenue | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 18 1949 | Greenville | South Carolina |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 18 1949 | [signature] | Mrs Katie Williams Sub | 3221 |

VS 150

14

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80938 ✓023 G80938

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) ELLA MAY MELZER

2. DATE OF DEATH December 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Franklin Square Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18-02
D. STREET ADDRESS (If rural, give location) 19 North Carey Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Single | July 7, 1899 | 54 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Clark Melzer

14. MOTHER'S MAIDEN NAME Anna

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs. Anna Johnston ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of liver

DUE TO

ANTECEDENT CAUSES

(B) (over)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE George H. Mercer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED Dec. 17, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Dec 17 49 | Denbigh Cem. | Warwick Virginia |

DATE RECEIVED BY LOCAL REGISTRAR DEC 18 1949

REGISTRAR'S SIGNATURE [illegible]

25. FUNERAL DIRECTOR Harry B Ritzke ADDRESS 30D

Form 191

CERTIFICATE CORRECTED 1-3-50 G80939

G 0939

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 153

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Belle Parsons

2. DATE OF DEATH: December 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore (Hospitalization) → Yrs. 1 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Charles
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Waldorf
D. STREET ADDRESS (If rural, give location):

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 5, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | U.S. |

13. FATHER'S NAME: Dr. Thomas Lynch

14. MOTHER'S MAIDEN NAME: Mollie Shermantine

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Mary Keim | 4810 Richard Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis

DUE TO

(B) Carcinoma of Sigmoid

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 18, 1949, *to* Dec. 17, 1949, *that I last saw the deceased alive on* Dec. 17, 1949, *and that death occurred at* 2:05 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John A. Slatter Jr. M. D. | Mercy Hospital | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Cedar Hill Cemetery | Woodstock Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR Sullivan ADDRESS |
|---|---|---|
| DEC 18 1949 | Huntington Williams, M.D. | Hunt & Ryon, Medford, Md. |

VS 150

46E

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80940 BALTIMORE CITY HEALTH DEPARTMENT G80940
# CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Jenkins
2. DATE OF DEATH: 12/16/49

3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 907 Bruce ST
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 16-03
c. Length of stay in Baltimore: 40 Yrs Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 907 Bruce St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | M. | | 68 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | S. Carolina | |

13. FATHER'S NAME: Boston Graham
14. MOTHER'S MAIDEN NAME: Marie Hampton

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 217-22-04 | Edward Graham | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) Acute Myocardial Failure
DUE TO
(C) Hypertensive Heart Disease

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Aug, 1949, to Dec 16, 1949, *that I last saw the deceased alive on* Dec 14, 19___, *and that death occurred at* 5 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| B. L. Banfield M. D. | 722 S. Fulton Ave | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Mt. Auburn | West Port. Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Commissioner Williams, M.D. | Metropolitan Funeral Home Inc | 937 N. Mount St |

VS 150

937

G80941 ✓ 2.3.4 G80941

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 41

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Katherine Taylor N-705 2

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospital

C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-04
D. STREET ADDRESS (If rural, give location): 417 E. 23rd St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Single | 2/15/1930 | 19 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Isaac Taylor
14. MOTHER'S MAIDEN NAME: Addie Elliott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Addie Taylor ADDRESS: 417 E. 23rd St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of neck, with compression of spinal cord.
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): public
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): North Pt. Rd. (auto. overturned twice) Erdman Avenue & Old
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: About Dec. 4, 1949 12:30 a.m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Driver of auto in which she was riding lost control of car and ran into grass plot

22. *I certify that I took charge of the remains described above, held an* ____ Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: George A. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec. 15, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/18/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A.A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 18 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 1412 E Preston St 170c

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80942

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80942

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Brown Marsden

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 437 E. 25th St.
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-03
D. STREET ADDRESS (If rural, give location): 437 E. 25th St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 12, 1867
9. AGE (In years last birthday): 82 yrs (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John J. Brown
14. MOTHER'S MAIDEN NAME: Annie R. Norris
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Wm. Klutz, 437 E. 25th St. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
(B) Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO
(C) Hypertension
Coronary Thrombosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 10th, 1949 *to* Dec 15, 1949 *that I last saw the deceased alive on* Dec 15, 1949, *and that death occurred at* 6.15P m., *from the causes and on the date stated above.*

23A. SIGNATURE: M. Ephraem, M. D.
23B. ADDRESS: 443 E. 25th St.
23C. DATE SIGNED: 12.16.49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 19, 1949
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: J. Miller Lamborn
ADDRESS: 4510 Liberty Heights Ave.

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80943

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

491 G80943

Registered No.

1. NAME OF DECEASED (Type or Print): REBECCA ABRAMS

2. DATE OF DEATH: 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale

C. Length of stay in Baltimore: 29 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): Levindale

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Albert Abrahams 2407 Loyola ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Diabetes mellitus, Arteriosclerosis

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1941, *to* 12-18, 1949, *that I last saw the deceased alive on* 12-18, 1949, *and that death occurred at* 6 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Nagel M. D.
23B. ADDRESS: Levindale Home
23C. DATE SIGNED: 12-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-18-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 18 1949
REGISTRAR'S SIGNATURE: Thomas Williams M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

61

G80944

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

411

G80944

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): JOSEPH ZALESKY
2. DATE OF DEATH: 12-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital
c. Length of stay in Baltimore: 36 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-11
D. STREET ADDRESS (If rural, give location): 3316 Dorithaw Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | ? | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Presser | Clothing | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Allen | Goldea |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Sadie Zalesky | 3316 Dorithaw Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Arteriosclerotic Cardio-vascular Disease | ? |
| DUE TO (B) | Rheumatic (?) Cardio-vascular Disease | ? |
| DUE TO (C) | Aortic Stenosis | ? |

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* April 19 49 *to* 12-17, 19 49 *that I last saw the deceased alive on* 12-17, 19 49 *and that death occurred at* 5-20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. E. Luscoman M. D. | 1109 N. Calvert St | 12-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-18-49 | Hebrew Young Men | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Transcription from Williams M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

92c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80945 BALTIMORE CITY HEALTH DEPARTMENT G80945

# CERTIFICATE OF DEATH

Registered No. 4150.0

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert L. Hilt Sr
2. DATE OF DEATH: Dec. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1606 N Chester St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 84 Yrs. 11 Mos. 18 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore — B. COUNTY: Maryland
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2-06
D. STREET ADDRESS (If rural, give location): 1606 N Chester Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | Feb 28, 1865 | 84 | 10 | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painters Decorator | | Baltimore Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles W Hilt (Germany) | Sarah Jowson (Baltimore Maryland) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Albert L Hilt Jr | 1606 N Chester Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO
(B) Bronchopneumonia
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 26, 1949 *to* Dec 16, 1949 *that I last saw the deceased alive on* Dec 16, 1949, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Donald Rubin M. D. | 1705 N Wash St | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 19, 1949 | Baltimore Cemetery | Baltimore Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Thurston Williams, M.D. | Albert L Hilt Jr | 1606 N Chester Street |

VS 150

107

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80946 ✓196 G80946

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William M. Henn Jr.

2. DATE OF DEATH: Dec. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 745 Poplar Grove St.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-06
D. STREET ADDRESS (If rural, give location): 745 Poplar Grove St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 2/21/1909 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Electrician | Phillips Elec. Co | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William M. Henn Sr. | Agnes V. O'Brien |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | | Leo. J. Henn | 1105 Walnut Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Sarcomatosis, DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Origin in approximately 4th + 5th lumbar vertebra DUE TO

(C) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 6 mos. (over)

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 12, 1949, to Dec. 16, 1949, *that I last saw the deceased alive on* Dec. 15, 1949, *and that death occurred at* 5:30 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. C. Battaglia M. D. | 5829 Belair Rd. 6 | Dec 17, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | New Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 18 1949 | Hunter for Williams, M.D. | John T. Stansbury | 2700 Edmondson Av. |

55B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80947 ✓ X G80947

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 433.1

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ELLA NOVAK

2. DATE OF DEATH 12/15/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL
c. Length of stay in Baltimore 5 0 7 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 7939 EASTERN AVE # 24

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | 9/12/1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | | PA. | |

13. FATHER'S NAME Thomas Rush

14. MOTHER'S MAIDEN NAME Mary Kajanka

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | MICHAEL NOVAK 7939 EASTERN AVE # 24 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) MULTIPLE EMBOLI — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) auricular fibulation

DUE TO

(C) Cardiac failure with anasarca 3 mo.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/14, 1949 *to* 12/15, 1949 *that I last saw the deceased alive on* 12/15, 1949, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| R. S. Martin M.D. M. D. | Maryland Gen. Hosp. | 12/15/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 19 1949 | Holy Rosary Cem | Balto County |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 18 1949 | | John M. Weber | 401 S. Chester Street |

VS 150

Washington Williams, M.D.

95a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

GM. 134228

BIRTH NO. C80948

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

401.3

Registered No. C80948

1. NAME OF DECEASED (Type or Print): Minnie Gertrude Webster — 660.0

2. DATE OF DEATH: 12-16- 1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2259 N. Fulton Ave. Z 17 — 13 3

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | March8- 1923 | 26 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | MD. | |

13. FATHER'S NAME: Jacob Jacobsen.

14 MOTHER'S MAIDEN NAME: Catherine Heathcote 49-27047

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | — | | Records B.C.H. 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Lobular Pneumonia And Cardiac Decomposition

DUE TO

(C) Rheumatic Heart Disease — over

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Pregnancy 34 Weeks

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12- 16- 49 | Delivery of Premature Living Child - Female | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12- 15- , 19 49 *to* 12- 16- , 49 , *that I last saw the deceased alive on* 12- 16- , 19 49 , *and that death occurred at* 10.47 AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. S. Rogan M. D. | B.C.H. 4940 Eastern Ave. | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 19/49 | St. Mary's, Hampden | Roland Ave, Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 18 1949 | Lennington Williams, M.D. | Austin E. Donovan | 3818 Poland Ave |

VS 150

95B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80949

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

260

Registered No. G80949

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elizabeth Willette (ELIZABETH WILLETTE BURNS) — 2. DATE OF DEATH 12-15-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE — B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Maryland, Baltimore

D. STREET ADDRESS (If rural, give location) 517 Robert St

c. Length of stay in Baltimore — Yrs. 5 months — Mos. — Days — 14-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widow | May 21, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Calvert Co. Md. | U.S.A. |

13. FATHER'S NAME: James Gray

14. MOTHER'S MAIDEN NAME: Eliza Chase

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Gerald Wilett | 517 Robert St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic coma & gangrene — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-23- 1949 *to* 12-15- 1949 *that I last saw the deceased alive on* 12-15- 1949 *and that death occurred at* 6:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Bradyth M. D. | Provident Hospital | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Dec. 19, 1949 | Family Lot. | Calvert Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 18 1949 | Huntington for Williams, M.D. | Holland Funeral Home | 1601 Druid Hill Ave |

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C80950 X 590 (C80950)

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hufford, Delbert

2. DATE OF DEATH: 12/18/49

3. PLACE OF DEATH: A. Baltimore City, Maryland St. Agnes Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore Md.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Wicomico
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salisbury - Bonne
D STREET ADDRESS (If rural, give location): 67 Madison St.

| 5. SEX | 6 COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | W | Married | 9/10/1905 | 44 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Worker
10B. KIND OF BUSINESS OR INDUSTRY: Peerless Trucking Co
11. BIRTHPLACE (State or foreign country): Md
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John M. Hufford
14 MOTHER'S MAIDEN NAME: Alice Eckhart

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO
17 INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ACUTE NEPHRITIS — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ACUTE CARDIAC FAILURE & PULMONARY EDEMA

DUE TO

(C) TERMINAL CEREMIA

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [4] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/6, 19xx *to* 12/18, 19xx *that I last saw the deceased alive on* 12/18, 19xx, *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D. | 23B ADDRESS: [illegible] Agnes Hosp. | 23C DATE SIGNED: 12/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal | 24B. DATE: 12/19/49 | 24C. NAME OF CEMETERY OR CREMATORY: Wyoming, Luzerne Co. Pa. | 24D LOCATION (City, Town, or County) (State): SAME

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949 | REGISTRAR'S SIGNATURE: Huntington for Williams, MD | 25 FUNERAL DIRECTOR: Wm Bork Inc | ADDRESS: 1217 St. Paul St.

VS 150

130

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80951

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80951

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dora Nusenko

2. DATE OF DEATH: 12/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balt. Gen. Hospital
c. Length of stay in Baltimore: 38 yrs (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1607 Ruxton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Russia | |

13. FATHER'S NAME: Jacob Bondareff

14. MOTHER'S MAIDEN NAME: Sonia Fine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Harry Nusenko — ADDRESS: 1607 Ruxton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute pulmonary edema | 48 hrs. |
| DUE TO (B) | Myocardial infarction | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10:15 A.M. 12/17, 1949, *to* 8:15 A.M. 12/18, 1949, *that I last saw the deceased alive on* 12/17, 1949, *and that death occurred at* 8:15 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Kathaniel V. Kemp M. D. | Balt. Gen. Hosp | 12/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec, 19, 1949 | Workmen Circle Cemetery | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 18 1949 | Huntington Williams, M.D. | Sol Levinson & Bros | 1126 W North Ave |

DEC 19 1949

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80952

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

294 Registered No. G80952

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isidore Greil

2. DATE OF DEATH: Dec 17, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — 3004 Chelsea Terrace
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3004 Chelsea Terrace
c. Length of stay in Baltimore: 48 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 3004 Chelsea Terrace 15-09

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov 28, 1880
9. AGE (In years last birthday): 69 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY: City Of Balto
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Raphael Greilsamer
14. MOTHER'S MAIDEN NAME: Nanette Meyer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Ralph S Greil — ADDRESS: 3004 Chelsea Terrace

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral hemorrhage | 1 day |
| DUE TO (B) | Polycythemia vera | 5 years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 24, 1949 *to* Dec 17, 1949 *that I last saw the deceased alive on* Dec 17, 1949 *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Irvin Farber M. D.
23B. ADDRESS: 3003 Garrison Blvd
23C. DATE SIGNED: 12-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 19, 1949
24C. NAME OF CEMETERY OR CREMATORY: Oheb Shalom Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Sol Levinson & Bros
ADDRESS: 1126 W North Ave

VS 150

83a

Correct age is especially important. Physician: please write the cause of death legibly.

G80953

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G80953

1. NAME OF DECEASED (Type or Print): ALICE MAE MARTZ

2. DATE OF DEATH: Dec. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashburton Nursing Home

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2106 E. Madison St. 7-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | July 15, 1880 | 69 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Baltimore, Md. | |

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Mrs. Gertrude Joyce | 2106 E. Madison St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1946 | Carcinoma of rectum | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 15, 1949, *to* Dec 16, 1949, *that I last saw the deceased alive on* Dec 16, 1949, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William E. Gilmore M. D. | 108 E 33rd St. Baltimore | Dec 19 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 19, 1949 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | [illegible] for Williams, M.D. | Ullrich Funeral Home | 2008 Orleans St., |

VS 150

467

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80954

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G80954

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clara Elsie Reedt

2. DATE OF DEATH: Dec. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location): St. Joseph's
C. Length of stay in Baltimore: 48 yr. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3912 Foster Ave. 26-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Widowed | 9/15/1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Wife. | | Germany | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Carl Reedt-6623 Bushey St. |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive cardiovascular disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 12, 1949 *to* Dec. 16, 1949, *that I last saw the deceased alive on* Dec. 16, 1949, *and that death occurred at* 4:42 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. H. Reams M. D. | 1400 N. Caroline St. | December 16, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 20/49 | Oak Lawn | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Ulman Funeral Home 2004 Aliceanna |

VS 150

93D

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80955

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50.0

G80955

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Samuel W. Sullivan

2. DATE OF DEATH 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18
D. STREET ADDRESS (If rural, give location) 117-Carrollton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Widowed | 4-17-76 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | | Baltimore, Md. | |

13. FATHER'S NAME Samuel Sullivan

14. MOTHER'S MAIDEN NAME Josephine Augustus

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Samuel W. Sullivan Jr. 1011 N. Arlington Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized Arteriosclerosis | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-18- 1949, *to* 12-18- 1949 *that I last saw the deceased alive on* 12-18 1949, *and that death occurred at* 2:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Brady Jr. M. D. | Provident Hosp | 12-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | Arbutus Mem. Park | Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 19 1949 | [illegible] | Mrs. Frances A. Hemsley 578 W. Biddle St. |

VS 150

97

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80956

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80956

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen Naomi Zemol

2. DATE OF DEATH: December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR (If not in hospital or institution, give street address or location): St. Joseph's
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Parkville
D. STREET ADDRESS (If rural, give location): 8322 Oakleigh Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Married | Dec 23, 1917 | 31 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Wife. | At Home | | |

13. FATHER'S NAME: John J. Boyd.

14. MOTHER'S MAIDEN NAME: Pauline Turnmaster

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Albert J. Zemel | 8322 Oakleigh Rd |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Massive pulmonary embolism

DUE TO

(B) Pulmonary infarcts, multiple

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* December 14, 1949 *to* December 18, 1949 *that I last saw the deceased alive on* Dec. 18, 1949, *and that death occurred at* 9:30 a m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thaddeus Swinski M. D. | 1400 N. Caroline St. | Dec. 18, 1949 |

| 24A. BURIAL, ~~CREMATION, REMOVAL~~ (Specify) | 24B. DATE | 24C. NAME OF CEMETERY ~~OR CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | London Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 1217 St. Paul St. |

VS 150

111a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80957 G80957

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 43

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Walter C. Wessels
2. DATE OF DEATH: Dec 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp
C. Length of stay in Baltimore: life — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15
D. STREET ADDRESS (If rural, give location): 3006 Clifton Ave 47

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | June 12, 1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Meat Dealer
10B. KIND OF BUSINESS OR INDUSTRY: Own
11. BIRTHPLACE (State or foreign country): Balto
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Litt Eaton Wessels
14. MOTHER'S MAIDEN NAME: Armstrong
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hammond Wessels ADDRESS: 3406 Rondaomin Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) intra ventricular cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hr.
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) hypertensive cardio vas. disease
DUE TO
(C)
II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 16, 19 49 *to* Dec 16, 19 49, *that I last saw the deceased alive on* Dec 16, 19 49, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Burton V Cook M.D. M. D.
23B. ADDRESS: Mercy Hosp
23C. DATE SIGNED: 12/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/19/49
24C. NAME OF CEMETERY OR CREMATORY: Abingdon
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St.

VS 150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80958 G80958

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1 97 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): QUENTIN M. HUMPHRIES

2. DATE OF DEATH: 12/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp. of Baltimore, Inc.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn Park
D. STREET ADDRESS (If rural, give location): 905 Victory Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | MARR | Nov 15. 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman | Latrobe Apts | Shiloh N C | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Humphries | Mattie Bray |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No | 220-09-8834 | Mrs Minnie Humphries 905 Victory Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fibromyxosarcomatosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 18, 1949 *to* Dec. 18, —, 1949 *that I last saw the deceased alive on* Dec. 18, 1949, *and that death occurred at* 3:50 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. Leonard Dessler M. D. | Sinai Hospital | Dec. 18, 1949 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Glen Haven | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 19 1949 | Huntington Williams, MD | Wm Cook Inc. 1217 St. Paul St. |

VS 150

55E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80953

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E816.5 G80953

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) HOWARD L. REIMSNYDER

2. DATE OF DEATH December 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland
B. COUNTY Howard
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hanover
D. STREET ADDRESS (If rural, give location)

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH June 29, 1910

9. AGE (In years last birthday) 39 (d.Jun) If under 1 Year: Months Days; If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic

10B. KIND OF BUSINESS OR INDUSTRY F.A.Davis

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Henry Reimsnyder

14. MOTHER'S MAIDEN NAME Anna L. Hollman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS Mrs. Alma Reimsnyder, Hanover, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Craneocerebral injury with multiple
DUE TO fractures of facial bones
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Highway

21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) Washington Blvd., St. Dennis, Md. 53.80

21D. TIME (Month) (Day) (Hour) OF INJURY 12-16-49 8:15 p. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR (driving on wrong side of road) Collision of auto. and bus

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE R S Fisher M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED 12-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/20/49

24C. NAME OF CEMETERY OR CREMATORY Nicholson Memorial

24D. LOCATION (City, town, or county) (State) Odenton, Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS William Cook, Inc., 1217 St. Paul St

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

170c

G80960

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80960

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LENA GIBSON JOHNSON

2. DATE OF DEATH: December 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
c. Length of stay in Baltimore: 5 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1510 W. Lexington Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | | 1887 | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Rocky Mt. N.C. | U.S.A. |

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | — | |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pulmonary tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D. | | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Community | Jarboro N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Baker Funeral Home | N.C. |

VS 151

13B

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G80961 Watts

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. G80961

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maude Watts

2. DATE OF DEATH: December 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore City, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3654 Old York Road

C. Length of stay in Baltimore: 3 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3654 Old York Road — 9-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | June 12, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Washington, D. C. | U.S.A. |

13. FATHER'S NAME: Thomas H. Buell

14. MOTHER'S MAIDEN NAME: Martha Parker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| No | | Mrs. Alton P. Watts-3654 Old York Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive Cardiovascular Disease — 2 yrs

(B) DUE TO: Pulmonary Oedema, acute — 6 hours.

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 1, 1949 *to* Dec 19, 1949, *that I last saw the deceased alive on* Dec 19, 1949 *and that death occurred at* 5:10A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William F. Pearce, M. D. | 2165 N Charles St | Dec 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12-21-49 | Congressional-Cemetery | Washington, D. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | WILLIAM J. TICKNER & SONS, INC. |

VS 150

93D

Information must be complete and correct as age is especially important. Physicians: please write the causes of death clearly and legibly.

G80962

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 181

G80962

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) **Kathern M. Boeger**

2. DATE OF DEATH **Dec. 16/49**

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **515 N. Loudon Ave,**
c. Length of stay in Baltimore **Life** Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **515 N. Loudon Ave.** 2007

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| **Female** | **W.** | **Widow** | **Oct. 30,1888** | **61** | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| **H.W.** | | **Md.** | |

13. FATHER'S NAME **George Kapraun**

14. MOTHER'S MAIDEN NAME **Barbara-----**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | **Mrs. Catherine Archer** | **515 N. Loudon** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carcinoma of Bladda | 3yrs |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 1947 *to* Dec 16, 1949 *that I last saw the deceased alive on* 12/13, 1949, *and that death occurred at* 3:20 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. L. Tolbert M. D. | 1945 W Balto St | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **12/20/49** | **Baltimore National** | **5501 Frederick Rd. Balto. Md** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Lexington Williams, MD | Harry A. Miller | 4101 Edmondson Ave. |

VS 150

52B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80963

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

60

G80963

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MRS. MARY JANE MOORE

2. DATE OF DEATH: 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. JOSEPH'S HOSPITAL

C. Length of stay in Baltimore: 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 16
D. STREET ADDRESS (If rural, give location): 2823 W. LAFAYETTE AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | MARRIED | March 27 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | LOCKPORT, N.Y. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Williams | Odele Proof |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Thomas S. Moody | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | BRONCHOPNEUMONIA | 24 HRS. |
| DUE TO (B) | DIBBETES MELLITUS + | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | DRY GANGRENE - LEFT FOOT. | |
| (C) | MID-THIGH AMPUTATION - LEFT. | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | BILATERAL CATARACTS | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| 12-16-49 | DRY GANGRENE - LEFT FOOT | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/22, 1949 *to* 12/18, 1949 *that I last saw the deceased alive on* 12/18, 1949, *and that death occurred at* 3:45 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William D. Tarlow, M. D. | St. Joseph's Hospital | 12-18-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | New Cathedral | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | [illegible] | Harry H. Witzke | 4101 Edmondson Ave |

VS 150

61

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80964 X ✓

BALTIMORE CITY HEALTH DEPARTMENT 43 G80964

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARION P. BARKMAN

2. DATE OF DEATH: 12-16-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Catonsville
D. STREET ADDRESS (If rural, give location): 316 S Hadywood Road

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married | 8. DATE OF BIRTH: 4-7- | 9. AGE (In years last birthday): 59 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Balto. Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles E. Barkman

14. MOTHER'S MAIDEN NAME: Lottie Wedi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HYPERTENSIVE ARTERIOSCLEROTIC — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO CARDIOVASCULAR DISEASE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) C CEREBRAL VASCULAR ACCIDENT
DUE TO LEFT AND RIGHT SIDED

(C) HEMAPLEGIA

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/12, 1949 *to* 12/16, 1949, *that I last saw the deceased alive on* 12/16, 1949, *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: John H. Shaw M.D. | 23B. ADDRESS: St. Agnes Hosp | 23C. DATE SIGNED: 12/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried | 24B. DATE: 12-19-49 | 24C. NAME OF CEMETERY OR CREMATORY: London Park | 24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Harry A. Wilke | ADDRESS: 4101 Edmondson Ave

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 12-19-49

G8096.5 BS-133941

401.3 G8096.5

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lydia Davenport Baptiste

2. DATE OF DEATH: 12-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
c. Length of stay in Baltimore: 25 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: ~~Baltimore~~
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Dundalk
D. STREET ADDRESS (If rural, give location): 124 Honeysuckle Ct.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | April 12, ~~1920~~ 1913 | 36 36 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Va. | |

13. FATHER'S NAME: Willie Davenport

14. MOTHER'S MAIDEN NAME: Janet Fallon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Records*Balto. City Hospitals | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Rheumatic Heart Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Uremia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-4 19 49 *to* 12-16 19 49 *that I last saw the deceased alive on* 12-16 19 49 *and that death occurred at* 11:05 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. B. Boozer M. D. | 4940 Eastern Avenue | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-49 | Mt. Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams M.D. | 916 Penna ave William Jackson | |

VS 150

95B

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80966 HAUF ✓ G80966

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 49-19119 CERTIFICATE OF DEATH 751 Registered No.

1. NAME OF DECEASED (Type or Print): Martin Joseph Hauf

2. DATE OF DEATH: 19 December 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1563 Homestead St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1563 Homestead St. Balto. Md. 9-07

D. STREET ADDRESS (If rural, give location): 1563 Homestead St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | single | Sept. 4-1949 | | 3 15 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Carl E. Hauf

14. MOTHER'S MAIDEN NAME: Mary Reilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) ✓

(If yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Hydrocephalous (congenital) | 3½ mo. |
| DUE TO | | | |
| ANTECEDENT CAUSES: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | | |
| DUE TO | | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | Spina Bifida & Meningocoele. congenital | |

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 25, 1949, to 19 Dec., 1949, *that I last saw the deceased alive on* Dec 5, 1949, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Thos L. Osborne M.D.

23B. ADDRESS: 5202 Harford Rd

23C. DATE SIGNED: 19 Dec. 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24B. DATE: Dec. 9/49

24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL

24D. LOCATION (City, town, or county) (State): Old Frederick Rd Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 9 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS: KRAUSE FUNERAL HOME 1216 S. CHARLES ST. BALTO 30

VS 150

157a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80967 ✓ Hyo. 1 G80967

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Lula Virginia Walker

2. DATE OF DEATH: Dec. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Home for Incurables

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home for Incurables

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2023 W. North Ave. 15 02

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: June 15, 1873
9. AGE (In years last birthday): 76 yrs (If under 1 Year: Months: 6, Days: 1; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): teacher
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John M. Walker
14. MOTHER'S MAIDEN NAME: Josephine Cox
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: no
17. INFORMANT: M. F. Owens ADDRESS: Home for Incurables

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 Minutes
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C) Rheumatoid Arthritis — 27 years

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/29, 1944 *to* 12/16, 1949, *that I last saw the deceased alive on* 12/15, 1949 *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. Grafton Hersperger M. D.
23B. ADDRESS: 214 Medical Arts Bldg.
23C. DATE SIGNED: 12/16/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/19/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25 FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

94a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80968

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G80968 Registered No.

1. NAME OF DECEASED (Type or Print) Morris Rosenblatt

2. DATE OF DEATH 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital
C. Length of stay in Baltimore 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 438 N. Gay St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 1875 | 74 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business man.
10B. KIND OF BUSINESS OR INDUSTRY Shoe Retail Business
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Elias Rosenblatt
14. MOTHER'S MAIDEN NAME Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No-
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Eva Rosenblatt ADDRESS 438 No Gay St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Intracranial Hemorrhage. | 9 hrs. ? |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Arteriosclerotic Cardiovascular Disease | 10 yrs. |
| | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-18-49 *to* 12-18-49 *that I last saw the deceased alive on* 12-18-49 *and that death occurred at* 1:55 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Margaret L. Sherard M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED 12-18-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-19-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY REGISTRAR DEC 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eutaw Pl

VS 150

937

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G80963

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

160.5

Registered No. G80963

BIRTH NO. 49-25589

1. NAME OF DECEASED (Type or Print) Jacqueline Clarice Harris

2. DATE OF DEATH 12-1-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp.
c. Length of stay in Baltimore Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-02
D. STREET ADDRESS (If rural, give location) 2131 W. Mulberry

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | Single | 11-21-49 | | | 9 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Vernon Harris
14. MOTHER'S MAIDEN NAME (Bernice) Beatrice Evelyn Norton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS —

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Prematurity

DUE TO

ANTECEDENT CAUSES

(B) Intracranial Hemorrhage

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION —
19B. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 11-21-49, 19[49], *to* 12-1-49, 19[49], *that I last saw the deceased alive on* 12-1, 19[49], *and that death occurred at* 6:[illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE Gothan Stuge M. D.
23B. ADDRESS Univ. Hosp.
23C. DATE SIGNED 12-9-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY University Medical School
24D. LOCATION (City, town, or county) (State) DEC 9 1949

DATE RECEIVED BY REGISTRAR DEC 9 1949
REGISTRAR'S SIGNATURE Huntington Williams, Mo
25. FUNERAL DIRECTOR Commissioner of Health
ADDRESS

VS 150

160a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G8097⌀ ✓ X 16 r. 5 G8097⌀

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 49-26960 Registered No.

1. NAME OF DECEASED (Type or Print) Baby John James HARVEY
2. DATE OF DEATH 12-14-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSP.
c. Length of stay in Baltimore 3 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) PIKESVILLE, MD.
D STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | | 12-10-49 | | | 34 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | U.S. |

13. FATHER'S NAME Charles Lewis HARVEY
14. MOTHER'S MAIDEN NAME Elizabeth SCHATZER.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bilateral Congenital Pulmonary Atelectasis | 3 Days |
| | DUE TO | |
| ANTECEDENT CAUSES | (B) Prematurity (38 wks). | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Twin. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-10 – , 1949, *to* 12-14-1949, *that I last saw the deceased alive on* 12-14-1949, *and that death occurred at* 1150A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H. Williams M.D. M. D. | Pikesville, Md. | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL DEC 16 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

159

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G809'71
B-116212

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4200

Registered No. G809'71

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Sloan

2. DATE OF DEATH: 12-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals

c. Length of stay in Baltimore: 12 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 139 Hill St. 22-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | Feb. 5, ? | 65? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | S.C. | |

13. FATHER'S NAME: Gabriel Sloan

14. MOTHER'S MAIDEN NAME: Jane Walker

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Records*Balto City Hospitals | 4940 EasternAve |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-30, 1947, *to* 12-17, 1949, *that I last saw the deceased alive on* 12-17, 1949, *and that death occurred at* 7:35 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. S. Rosen M. D. | 4940 Eastern Avenue | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | Mt Calvary | a.a. Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, MD | James A Hayes | 638 N. Gilmor St |

VS 150

93D

Please write plainly. Physician: please write the causes of death clearly and legibly. Cause of age is especially important.

G80972

BIRTH NO. Y-66493

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

591 Registered No.

G80972

1. NAME OF DECEASED (Type or Print): DANIEL JOSEPH SCHUELER

2. DATE OF DEATH: 12-17-99

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL

c. Length of stay in Baltimore: 2 Yrs. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALT. 16-08
D. STREET ADDRESS (If rural, give location): 622 MT. HOLLY STREET

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | CHILD | JAN. 2, 1947 | 2 | 10 | 14 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHILD

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CARROLL E. SCHUELER

14. MOTHER'S MAIDEN NAME: NANCY ELLARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mr. Carroll E. Schueler ADDRESS 622 Mt. Holly St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CIRCULATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 4 HRS.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) NEPHROSIS. — 2 MONTHS

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —

19B. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV. 10, 1949, *to* DEC. 17, 1999 *that I last saw the deceased alive on* DEC. 17, 1999, *and that death occurred at* 3:05 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: J.A. Roberts M.D. M.D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 12-17-99

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/20/49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: John J. Toomey & Sons ADDRESS: 2 Wolfe St.

VS 150

133B

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80973

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80973

BIRTH NO. 49-22858

1. NAME OF DECEASED (Type or Print) James Edward Hopkins

2. DATE OF DEATH 10/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 733 Wilmer Court

C. Length of stay in Baltimore 40 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 17-01
D. STREET ADDRESS (If rural, give location) 733 Wilmer Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | 10/27/49 | | | 40 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Walter Clarence Hopkins

14. MOTHER'S MAIDEN NAME Mary Lillian Lore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Walter ADDRESS 733 Wilmer Court

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Birth

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Home

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/27/49 5:15 P.M.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Birth

22. *I hereby certify that I attended the deceased from* 10/27/49, 19__, *to* 10/27/49, 19__, *that I last saw the deceased alive on* Oct 27, 49, *and that death occurred at* 5:15 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M.D.

23B. ADDRESS Balto. City

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY JOHN HOPKINS MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State) DEC 8 1949

DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS

VS 150

159

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

C809'74

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C809'74

BIRTH NO. M-79916

1. NAME OF DECEASED (Type or Print): Edward B. Sager (462533?)

2. DATE OF DEATH: DEC 17 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, City
D. STREET ADDRESS (If rural, give location): 1421 Cooksie, St. 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | | 5-31-47 | 2 | 6 | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Balto. Md. | U.S.A. |

13. FATHER'S NAME: John H. Sager

14. MOTHER'S MAIDEN NAME: Margaret H. Staffa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Pyocyaneous Meningitis | 7 d |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Reduplication of Duodenum | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | DUE TO (C) Gastrointestinal Hemorrhage | 1 day |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20- 1949 *to* 12-17- 1949 *that I last saw the deceased alive on* 12-17- 1949, *and that death occurred at* 12½ m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. C. Robinson M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 12-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/19/1949

24C. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.

24D. LOCATION (City, town, or county) (State): A. A. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Flynn & Fleming 1426 Light St.

1578

VS 150

Please write the causes of death clearly and legibly. Physician, please write the causes of death clearly and legibly. Physician, please write the causes of death clearly and legibly. Physician,

G80975

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80975
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice Thomas

2. DATE OF DEATH: 12-15-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1005 W. Lanvale
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1005 W. Lanvale St
C. Length of stay in Baltimore: 5 Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: 1005 W. Lanvale St
B. COUNTY: Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16 Ct
D. STREET ADDRESS (If rural, give location): 1005 W. Lanvale St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | C | married | Oct. 2, 1890 | 59 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Taylor. | Martha Farrell. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | William B. Thomas. | 1005 W. Lanvale |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: not known
DUE TO
(B) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-7, 1949 *to* 12-15, 1949 *that I last saw the deceased alive on* 12-15 1949 *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|---|
| Charles T. Waddell | | 821 Hanlon St | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-19-1949 | Balto. National | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Wm. Katie R. Williams | 3209 Sch... |

VS 150

46E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C80976

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 974 C80976 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Kuczusky (Kucawski) N-991

2. DATE OF DEATH: Nov. 10, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 608 E. Pratt St. 4-01

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 1882
9. AGE (In years last birthday): 67
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Asphyxia by hanging | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Public Place
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 500 ft. from Cinder Rd., Bay View Rd. Pa. Ave.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 1949 ? m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Hanged self by rope from tree

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ homicide ☐, undetermined ☐.*

23A. SIGNATURE: [signature] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Nov. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: PUBLIC CEMETERY
24D. LOCATION (City, town, or county) (State): DEC 15 1949

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: [signature], M.D.
25. FUNERAL DIRECTOR: Commissioner of Health ADDRESS:

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished correct age is especially important. Physicians: please write the cause of death clearly and legibly.

164a

C809.7 ✓X

BALTIMORE CITY HEALTH DEPARTMENT 66

# CERTIFICATE OF DEATH

C809.7

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) HENRY FREY

2. DATE OF DEATH 12/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL

C. Length of stay in Baltimore 5-3 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE Govanlea
D. STREET ADDRESS (If rural, give location) 7829 BELAIR RD #4

5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH May 25 - 1896 | 9. AGE (In years last birthday) 53 | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | 10B. KIND OF BUSINESS OR INDUSTRY Jewelery

11. BIRTHPLACE (State or foreign country) Baltimore MD. | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Frederick L. Frey

14. MOTHER'S MAIDEN NAME Pauline Cakes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO 218-06-2322

17. INFORMANT Ruth C Frey ADDRESS 7829 Belair Rd Balto. Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Gangrene Lower Extremities — INTERVAL BETWEEN ONSET AND DEATH: 1½ MO

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Thrombosis Femoral Veins bilateral & Pulmonary Embolism of Vena Cava. — 1½ MO

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 10/31/49 | 19B. MAJOR FINDINGS OF OPERATION Thrombosis femoral veins left of attending Embolus Vena Cava | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/31, 1949 *to* 12/17, 1949, *that I last saw the deceased alive on* 12/14, 1949, *and that death occurred at* 4:20 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE R. E. Martin M.D. | 23B. ADDRESS Maryland Gen. Hosp. | 23C. DATE SIGNED 12/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify) burial | 24B. DATE 12/20/49 | 24C. NAME OF CEMETERY OR CREMATORY Baltimore | 24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR Lassahn Funeral Home | ADDRESS 7401 Belair Rd.

VS 150

100 B

PLEASE WRITE LEGIBLY. Physicians: please write the cause of death clearly and correct age is especially important.

MB-134130

G809'78
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

33

G809'78
Registered No.

1. NAME OF DECEASED (Type or Print): Frank Thornton

2. DATE OF DEATH: 12-16-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 325 Bruce Street 19-01

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: ? ? 1880
9. AGE (In years last birthday): 69?
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: (B)everly Thonton
14. MOTHER'S MAIDEN NAME: Elizabeth Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Probable Cerebral Vascular Thrombosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pulmonary Edema | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10- , 1949, *to* 12-16- , 1949, *that I last saw the deceased alive on* 12-16- 1949, *and that death occurred at* 10:10 AM, *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 12-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-20-49
24C. NAME OF CEMETERY OR CREMATORY: Western Star
24D. LOCATION (City, town, or county) (State): Catonsville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR ADDRESS: F.C. Higinbotham, Ellicott City, Md.

VS 150

836

PLEASE WRITE PLAINLY WITH UNFADING INK. ENTRIES MUST BE MADE IN ALL SPACES. If none, write NONE. If unknown, or not applicable, write UNKNOWN. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

MS—132952

G80973

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80973

1. NAME OF DECEASED (Type or Print): Vivian Haynes

2. DATE OF DEATH: 12-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
COUNTY: Prince George
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Rural—Laurel
D. STREET ADDRESS (If rural, give location): 817 Montgomery St. Laurel Zone 17

5. SEX: Female
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 9, 1941
9. AGE (In years last birthday): 8 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas W. Haynes
14. MOTHER'S MAIDEN NAME: Freida Kreney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: no
17. INFORMANT: Records—Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tuberculous Meningitis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-27-, 1949, *to* 12-17-, 1949, *that I last saw the deceased alive on* 12-17- 19 49, *and that death occurred at* 3:45 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. L. Rosen M. D.
23B. ADDRESS: B.C.H.—4940 Eastern Ave.
23C. DATE SIGNED: 12-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-20-49
24C. NAME OF CEMETERY OR CREMATORY: Ivy Hill
24D. LOCATION (City, town, or county) (State): Laurel Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: DeWitt Donaldson, ADDRESS: Laurel Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

14

For Removal of Body

BIRTH NO. L80930 M.C.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80930

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) J. P. McCURDY | 2. DATE OF DEATH 12-17-49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1415 E. Biddle St. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. 10-01 |
| c. Length of stay in Baltimore 21 days (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location) 1415 E. BIDDLE ST. |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | C. | Widow | 10-12-1867 | 82 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| FARMER. | | N. C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Philip McCURDY | PATSY ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

DUE TO

(B) Hypertensive Cardio Vascular Disease ? — '

DUE TO

(C) Arteriosclerosis — '

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

0

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-17, 19 49 *to* 12-17, 19 49 *that I last saw the deceased alive on* 12-17, 19 49 *and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. R. Adams M. D. | 1222 N. Carrollton | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| REMOVAL | 12-19-49 | North Wilkesboro | N. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Joseph S. Rock, Jr. | 1304 N. Carrollton |

VS 150

93D

GIVE WHITE LABEL ONLY WITH CAUSE OF DEATH. THIS LABEL IS FOR FILING THE CERTIFICATE. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80981

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G80981 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Bartholomew

2. DATE OF DEATH: 12/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 437 N. Kenwood Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md 6-01
D. STREET ADDRESS (If rural, give location): 437 N. Kenwood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | D | Mar. 17-1900 | 49 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Childs nurse

10B. KIND OF BUSINESS OR INDUSTRY: Private Homes

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob Kruszewski

14. MOTHER'S MAIDEN NAME: Rose Zakrzewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Cecilia Fox ADDRESS: 437 N. Kenwood Ave

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive cardiovascular disease | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: P. J. Lubinski M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑

23C. DATE SIGNED: 12/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec. 21-49

24C. NAME OF CEMETERY OR CREMATORY: Holy Rosary

24D. LOCATION (City, town, or county) (State): Balto. Co.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949

REGISTRAR'S SIGNATURE: Wellington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. S. Fialkowski ADDRESS: 2007 Eastern Ave

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G80982 X G80982

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Herbert Sales (HERBERT F. SALES)

2. DATE OF DEATH: Dec 17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY: 935 Martin Rd Balto Co
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lesser Lutz
D. STREET ADDRESS (If rural, give location): 935 Martin Rd Balto Co

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If less than 1 day) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | 4/28/01 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Knapp Shoe Co | Balto Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| — Sales | Ada — — |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| — — | 216-09-2791 | Effie Sales, 935 Martin Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

(B) Coronary thrombosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hypertensive Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/16 1949 *to* 12/17 1949 *that I last saw the deceased alive on* 12/17 1949 *and that death occurred at* 3 50 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerome Gaber M. D. | Sinai Hosp. | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 21/49 | Baltimore | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Phillips Stevens Sons | 202 Calhoun St |

PLEASE WRITE PLAINLY. Fill out every item. Every item is important. Physicians: please write the cause of death clearly and legibly. Be sure the cause is especially correct age is especially important.

93D

G80983 BALTIMORE CITY HEALTH DEPARTMENT G80983

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): David Gibson
2. DATE OF DEATH: 12/18/49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Mercy Hosp
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore: 45 yrs. (Yrs. / Mos. / Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: 612 E. Pratt St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 612 E. Pratt St. 4-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | M.- | 10/1874 | 75 | 1 | 8 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Man
10B. KIND OF BUSINESS OR INDUSTRY: Oasis Club.
11. BIRTHPLACE (State or foreign country): Phila Penna.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: John J. Gibson
14. MOTHER'S MAIDEN NAME: Mary McGarrigan
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
16. (If yes, give war or dates of service)
SOCIAL SECURITY NO.
17. INFORMANT: Margaret Gibson — ADDRESS: 3904 W. Mulberry St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Alcoholism
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐
21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Accident

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: Emil H Beyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/21/49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Moriah
24D. LOCATION (City, town, or county) (State): Phila Penna

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Philip Henry Sons — ADDRESS: 2027 Orleans St

VS 151

77c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as is especially important. Physician: please write the cause of death clearly and legibly.

G80984 ✓ G80984

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 89.0

Registered No.

1. NAME OF DECEASED (Type or Print) HARRY B. FORD — N-968 D

2. DATE OF DEATH December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
University Hospital

C. Length of stay in Baltimore — Yrs. 4 Mos. - Days 0 ✓

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 666 W. Baltimore Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | W. | May 22 1871 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | — | Md | ✓ |

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | — |

17. INFORMANT David A. Ford ADDRESS 1428 Forge Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carbon monoxide poisoning

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) rear room first floor at 666 W. Baltimore St.

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY December 17, 1949 ? a. m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR? Gas oven burner open but unlighted

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE R S Fisher. M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Dec. 19, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | London Park. | Frederick Rd. |

DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949

REGISTRAR'S SIGNATURE Tunstall Williams, M.D.

25 FUNERAL DIRECTOR ADDRESS Paul E. Schenouver 3615-17 Edmondson Ave.

VS 151

178a ✓

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80985 ✓ X EP19.4 G80985

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No. N-803.2

1. NAME OF DECEASED (Type or Print): THEODORE SWANNER
2. DATE OF DEATH: 12/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland B. C. Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: A.A.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brooklyn
D. STREET ADDRESS (If rural, give location): 5829 Ritchie Highway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | D | 9/16/17 | 32 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Cemetery | Baltimore | |

13. FATHER'S NAME: Theodore I. Swanner Jr.
14. MOTHER'S MAIDEN NAME: Margaret C. Falkenhan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes WWII | | Family - Same | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Contusion of brain
DUE TO
(B) Intracranial hemorrhage. Fracture skull
DUE TO
(C)

ANTECEDENT CAUSES

II
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): street
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): East bound on O'Donnell St. when at Quaqren
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12-16-49 about 10 p. m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Auto. into berrier, then into air-compressor and then down a large hole

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Thos G. Merrill M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 12/17/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/21/49 | Oak Lawn | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, MD | Jas. L. McCauley | 130 East Fort Av |

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

170c

G80986

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80986

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZABETH M. FREDERICK

2. DATE OF DEATH: 12-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3715 FOSTER AVE
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 26-09
D. STREET ADDRESS (If rural, give location): 3715 FOSTER AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | JAN. 11 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | At Home | Balto. County-MD | |

13. FATHER'S NAME: John Kelmaster

14. MOTHER'S MAIDEN NAME: Lena Kolf

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT (Name) | ADDRESS |
|---|---|---|---|---|
| No | | | Conrad Frederick | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Cardiac Failure
DUE TO
(B) Hypertensive Cardio-Vascular Disease — 6 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 1949 *to* Dec. 17, 1949 *that I last saw the deceased alive on* 12/15 1949 *and that death occurred at* 9:00 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A B Stevens M. D. | 3400 Eastern Ave | 12/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/1949 | Parkwood Cemetery | Gaithersburg-Parkville |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | J. Walter Conklin | 3343 Mayfield Ave. |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80987

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

113 Registered No. G80987

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs Anna R Pettlett

2. DATE OF DEATH Dec. 17 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Home for Incurables of Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home for Incurables of Baltimore City

c. Length of stay in Baltimore 46 Yrs. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15 13-07
D. STREET ADDRESS (If rural, give location) 40[illegible] St. & Keswick Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months Days | If under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | W | | May 20 1873 | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Nursing | | Virginia | U.S.A. |

13. FATHER'S NAME John Pettlett

14. MOTHER'S MAIDEN NAME Smith

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | M. F Owens | Home for Incurables |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 6 days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Hypertensive Cardio-Vasc. Dis. | 12 years + |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Mitral and Aortic Rheumatic Endocarditis | 20 years + |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Feb. 1st, 1938, *to* Dec. 17, 1949, *that I last saw the deceased alive on* Dec. 16, 1949, *and that death occurred at* 4:20 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Conrad Wood M.D. | 11 E. Chase St. Baltimore 15 | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to fill in all items. Be exact as to time of death and age. Physician: please write the cause of death clearly and legibly. Be exact as to time of death and age is especially important.

C80988

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C80988

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EVA HIPP

2. DATE OF DEATH: Dec. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinecrest Nursing Home, 600 S. Chapel Gate Lane

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1500 Moreland Ave. 15-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | widow | Jan. 1, 1864 | 85 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Germany | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| -- Fischer | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Andrew Hipp | 1500 Moreland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized Arteriosclerosis | ? |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Senility | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 2, 1944, 19 49, *to* December 6, 1944, *that I last saw the deceased alive on* Dec 17, 1949, *and that death occurred at* 2:45 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin M. Borden M. D. | 2030 W. Fayette St | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G80983

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80983

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): MARY CAROLINE STROTT

2. DATE OF DEATH: Dec. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shriner Nursing Home, 3520 N. Hilton Rd.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2211 N. Fayette St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Oct. 4, 1871 | 78 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Chambersburg, Pa. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles M. Lindner | Mary A. Hibbert |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Louis L. Strott | 2211 N. Fayette St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Thrombosis

DUE TO

(B) marked, generalized, arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic arthritis, hypertrophic

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12 Dec, 1949, *to* 18 Dec, 1949 *that I last saw the deceased alive on* 18 Dec, 1949 *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil H. Flemming Jr. M.D. | 601 Wilkens Way | 19 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

836

G80990

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-1.0

G80990

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAY WARREN ROSE

2. DATE OF DEATH: Dec. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 232 N. Monastery Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 232 N. Monastery Ave. 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Oct. 8, 1883 | 66 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Baltimore, Md. | |

13. FATHER'S NAME: Charles C. Dews

14. MOTHER'S MAIDEN NAME: Margaret Tierney

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Clarence E. Rose | 232 N. MonasteryAv |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral insufficiency

DUE TO

ANTECEDENT CAUSES

(B) Congestive heart failure

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 5, 1949 *to* Dec 17, 1949, *that I last saw the deceased alive on* Dec 17 1949 *and that death occurred at* 9 00 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Milton Lasseigne M. D. | 2 N Ellamont St | Dec 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12.20.49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

920

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80991

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80991

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edwin A. Fitzpatrick

2. DATE OF DEATH: 12-17-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2609 Chelsea Terrace

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2609 Chelsea Terr.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Oct. 4, 1890 | 59 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Broker ------ | Real Estate | Baltimore, Md. | |

13. FATHER'S NAME: Charles Fitzpatrick

14. MOTHER'S MAIDEN NAME: Lillian Norma

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 218-05-4615 | Mr. Edwin A. Fitzpatrick | Charles Town W. Va. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Heart Disease — Interval between onset and death: 4 hours

DUE TO

(B) Hypertensive Cardio-vascular disease — Interval between onset and death: Unknown

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Robert B. McAdden M.D. | | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

93-151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93D

G80992

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 ✓ G80992 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) James Smith

2. DATE OF DEATH 12/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 422 N. Durham St
C. Length of stay in Baltimore 18 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 422 N. Durham 6-54

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | N | Married | Sept. 19. 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | General | Eastern Shore Md | U. S. A. |

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs. Smith | 422 N. Durham St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive C-V Renal Dis. 3 Mo.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/12 19[illegible] *to* 12/18 19[illegible], *that I last saw the deceased alive on* 12/12 19[illegible], *and that death occurred at* 11[illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Carter Hart M. D. | 601 N. Carrollton | 12/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | Mt. Olivet Cem. | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams M.D. | Elwood Wilson | 1000 Brantly Rd |

VS 150

131a

MS—21734

G80993

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G80993

BIRTH NO.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If entirely unknown, write "unknown". Physician: please write the cause of death clearly and legibly. Correct age is especially important.

1. NAME OF DECEASED (Type or Print) Adeline Williams

2. DATE OF DEATH 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 814 W. Mulberry St. 18-01

5. SEX Female
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Aug. 31, 1890
9. AGE (In years) last birthday) 59 If Under 1 Year: Months, Days. If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10B. KIND OF BUSINESS OR INDUSTRY at Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gus Williams
14. MOTHER'S MAIDEN NAME Lettie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS Baltimore City Hospitals Records—4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive arteriosclerotic heart disease, with failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Left hemiplegia, old

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-9- , 1937, *to* 12-15- , 1949, *that I last saw the deceased alive on* 12-15- , 1949 *and that death occurred at* 10:10 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE P. L. Rozen M. D.
23B. ADDRESS B.C.H.—4940 Eastern Ave.
23C. DATE SIGNED 12-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/19/49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.
24D. LOCATION (City, town, or county) (State) Brooklyn Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
FUNERAL DIRECTOR Henry D. Wilson
ADDRESS 1005 Fleet St.
DEC 19 1949

937

G80994
NS—134187

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G80994
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel Reed
2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 39 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 55 N. Caroline St. Zone 31

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Single | Sept. 10th 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | General | South Carolina | U.S.A. |

13. FATHER'S NAME: ? ? ? Unkown
14. MOTHER'S MAIDEN NAME: ? ? ? Unkown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT'S ADDRESS |
|---|---|---|
| No | | Baltimore City Hospitals Records—4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Miliary Tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-13- , 1949 *to* 12-15- , 1949, *that I last saw the deceased alive on* 12-15- , 1949, *and that death occurred at* 8:25A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | B.C.H.—4940 Eastern Ave. | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/1949 | Charleston Cem. | Charleston S.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 19 1949 | Livingston Williams, M.D. | Elley S. Tyler 1000 Brently Ave. |

DEC 19 1949

Vs 3-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

13B

CERTIFICATE CORRECTED 12-27-49

G80995 BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G80995 Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM E. PARK

2. DATE OF DEATH: Dec. 16, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. S. Marine Hospital, Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: 6 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland B. COUNTY: Baltimore city
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3719 Woodbine Avenue

28-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | Aug 28, 1874 ~~15, 1885~~ | 75 ~~64~~ | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10B. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles E. ~~William~~ Park

14. MOTHER'S MAIDEN NAME: ~~Margaret Diwards~~ Nettie Paddock

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| yes | WW I | Unkn. |

17. INFORMANT ADDRESS: Records - US Marine Hospital, Balto., Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 27 days

DUE TO

(B) cerebral arteriosclerosis — unknown

DUE TO

(C) hypertensive cardiovascular disease — unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. hypertensive cardiovascular disease — unknown

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 19, 1949 *to* Dec 16, 1949, *that I last saw the deceased alive on* Dec 16, 1949 *and that death occurred at* 10:10 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE, M. D.: F. L. Lewis, Jr. O.O.D.

23B. ADDRESS: % U S Marine Hosp. Balto, 11, Md

23C. DATE SIGNED: 12-17-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal

24B. DATE: 12/20/49

24C. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

24D. LOCATION (City, town, or county): Arlington, Va.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949

REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR ADDRESS: WM. J. TICKNER & SONS Balto., Md.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

93D

G80996

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80996

BIRTH NO. 49-17657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | MARILYN | DELORES | MAKOWSKI |
| 2. DATE OF DEATH | December 18, 1949 | | |

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
1629 Gwynn Falls Avenue

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1629 Gwynn Falls Avenue 13-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | | Aug. 21, 1949 | | 4 3 | 25 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | | Baltimore | |

13. FATHER'S NAME: Edward J. Makowski

14. MOTHER'S MAIDEN NAME: Lillian Babitz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Edward Makowski | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia

DUE TO

(B) Streptococcus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* ~~natural causes~~ [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| H. J. McClafferty M.D. | [X] | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 21, 1949 | St. Stanislaus | Baltimore, Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12/19/49 | Huntington Williams, MD | FRED W. OZALEWSKI | 1930 Eastern Avenue |

VS 151

24a

G80997

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G80997

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles (Krause) KRAUSS

2. DATE OF DEATH: Dec. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): So. Balt. Gen'l. (DOA)

C. Length of stay in Baltimore: Life - Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12 07
D. STREET ADDRESS (If rural, give location): 408 W. 28th St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | June 12, 1912 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber | H.E. Crook Co. - Plumbing | Baltimore | U.S.A. |

13. FATHER'S NAME: Edward Krauss

14. MOTHER'S MAIDEN NAME: Dertha Wachsmuth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-01-7559

17. INFORMANT: Mrs. Katherine M. Krauss (Wife) ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Hypertensive cardiovascular disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Emil H. Beyer M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 19 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: Dec. 21, 1949 | 24C. NAME OF CEMETERY OR CREMATORY: Western Cemetery | 24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, MD | 25. FUNERAL DIRECTOR: C. Howard Evans ADDRESS: 1400 S Charles St Balto 30 Md. 937

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician: please write the causes of death clearly and legibly.

G80998

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. 3697

G80998

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Pearl Price

2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1114 Linden ave
C. Length of stay in Baltimore: ? over 5 years (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-04
D. STREET ADDRESS (If rural, give location): 1114 Linden Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | own home | N. C. | U.S.A. |

13. FATHER'S NAME: James Smyth

14. MOTHER'S MAIDEN NAME: Sarah Harris

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Perry Price | 1114 Linden ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocarditis | one years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Arterio Sclerosis + hypertension | unknown |
| DUE TO (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1-1-, 1944, *to* 12-15-, 1949, *that I last saw the deceased alive on* 12-14, 1949, *and that death occurred at* 2:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank A. Saunders M. D. | 1099 N. Stricker St. | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/19/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Wanting for Williams, M.D. | Isaac L Brownson | 108 W Montgomery St |

Vs 150

92D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G80993

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. G80993

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nora B Hall.

2. DATE OF DEATH: December 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 27-03
D. STREET ADDRESS (If rural, give location): 5002 Ross Rd. 19

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | WIDOWED. | Aug. 18-1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cashier | | Virginia. | |

13. FATHER'S NAME: ✓ BAILEY

14. MOTHER'S MAIDEN NAME: MayBelle ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mr. Charles M. Hall | 4309 Alan Drive |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Pulmonary edema. | 30 minutes |
| DUE TO (B) | Sub-arachnoid hemorrhage. | 28 hours. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Hypertensive Cardio-Vascular Disease. | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-15-49, 19__, *to* 12-16 49, 19__, *that I last saw the deceased alive on* 12-16, 1949, *and that death occurred at* 11:35 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Patterson Mack M.D. | University Hospital | 12-16-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Oaklawn | Bolto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Turlington Williams, M.D. | Lemuel J. Fuck | 5205 Harford |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

Dr. Blake

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 681000

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elmina Dudley

2. DATE OF DEATH: Dec 19-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Post Graduate 3025 Madison Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 18 Ward; D. STREET ADDRESS (If rural, give location) 1217 N. Fayette St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last Birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | widowed | Jan. 15-1866 | 83 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Maryland | |

13. FATHER'S NAME: John Wesley Lee

14. MOTHER'S MAIDEN NAME: Mobrine Chance

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Evelyn Emerine ADDRESS: 5[illegible] Murdock

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: several years

DUE TO

(B) acute dilatation. — 6 mths.

DUE TO

(C) Old age.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 5 1949 *to* Dec. 19 1949, *that I last saw the deceased alive on* Dec 18, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert C. Blake M. D. | Med. arts Bldg | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Moreland Park | Balto Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949

REGISTRAR'S SIGNATURE: [signature]

25. FUNERAL DIRECTOR: Leonard J Luck ADDRESS: 5305 Harford

93D

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81001

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81001

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN SCOTT

2. DATE OF DEATH December 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2013 Brunt Street 14 - 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | married | Oct 29, 1907 | 42 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | | Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| — | — |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs. Mary Scott | 2013 Brunt St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary embolism

DUE TO

(B) Hypertrophy and dilatation of heart

DUE TO

(C) Syphilitic aortitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Dec. 17, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-49 | mt Auburn | md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams | George G. Nelson | 1303 Pratt Street |

VS 1ST

307

G81002

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81002

1. NAME OF DECEASED (Type or Print): EMMA KATHERINE BEWLEY

2. DATE OF DEATH: 12/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 540 S. Bentalou St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Catonsville
D. STREET ADDRESS (If rural, give location): 2318 Powers Lane

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 24/89
9. AGE (If under 1 year, last birthday): 60 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Herman Schneider
14. MOTHER'S MAIDEN NAME: Minnie Emrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO: None
17. INFORMANT: Ethel M. Bewley
ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Oedema
DUE TO
(B) Cardio Vascular Disease
DUE TO
(C) Hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 16, 1949, *to* Dec 18, 1949, *that I last saw the deceased alive on* Dec 18, 1949, *and that death occurred at* 8 9 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert C. Metcalf, M. D.
23B. ADDRESS: 215 Walker Av
23C. DATE SIGNED: 12-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 21/49
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Catherine Williams, M.D.
25. FUNERAL DIRECTOR: Easton Jones
ADDRESS: Catonsville Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

93D

G8T003

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 447

G8T003

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAMIE C HARBAUGH

2 DATE OF DEATH: DEC-18-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1217 PATAPSCO ST.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: 61 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE MD
D STREET ADDRESS (If rural, give location): 1217 PATAPSCO ST

| 5. SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | WIDOW | JAN-17-1888 | 61 | 11 / 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | | BALTIMORE MD | U S |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| JOSEPH WAGNER | MARY HARTMAN |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | EDW. HARBAUGH | 1217 PATAPSCO ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic nephritis — DUE TO

(B) myocarditis — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| / / m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 6, 1949 *to* Dec 18, 1949, *that I last saw the deceased alive on* Dec 16, 1949, *and that death occurred at* 12·17 m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Rubin M. D. | 203 Patapsco ave | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC-21-49 | HOLY CROSS CEM. | A. A. Co MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, MD | Bernard C Hunle | 121 E. WEST ST. |

VS 150 DR RUBIN 203 PATAPSCO AVE 1216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G81003 G81004

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 410

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Mavie M. Gadow

2. DATE OF DEATH: Dec. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 38 N. Marley St. 20 07

5. SEX: F.
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 1899
9. AGE (In years last birthday): 50 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Anton Riedel
14. MOTHER'S MAIDEN NAME: Rosa Finkel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Rev. Gilbert Golan — ADDRESS: St. Johns Rectory

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart failure
DUE TO
(B) Mitral Stenosis And Insufficiency
DUE TO
(C) Rheumatic CVD

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Auricular fibrillation

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 16, 1949, *to* Dec. 17, 1949 *that I last saw the deceased alive on* Dec. 17, 1949 *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: D. L. Mahler M. D.
23B. ADDRESS: Bon Secours Hosp.
23C. DATE SIGNED: 12/17/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-21-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Anne Arundel County

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: George D. Farley — ADDRESS: Fulton Ave Baltimore

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

92c

G81005 **BALTIMORE CITY HEALTH DEPARTMENT** G81005

BIRTH NO. **CERTIFICATE OF DEATH** Registered No.

1. NAME OF DECEASED (Type or Print): IDA ELIZABETH SCHAEFER

2. DATE OF DEATH: 12/18/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore Gen. Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3610 Loudon Rd

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan. 19, 1875
9. AGE (In years last birthday): 74 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HW
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas J. Harden
14. MOTHER'S MAIDEN NAME: Anna Caroline Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Miss Maude M. Schaefer
ADDRESS: 3610 Harford Rd.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.
DUE TO
(B) Arteriosclerotic heart disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Dec 4 19 49 *to* Dec 18 19 49 *that I last saw the deceased alive on* 12/18 19 49 *and that death occurred at* 9:45 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1213 Leigh St.
23C. DATE SIGNED: 12/18/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/21/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
24D. LOCATION (City, town, or county) (State): Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 19 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS
ADDRESS: Balto., Md.

VS 150

DEC 19 1949

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correct age is especially important. Physician: please write the cause of death clearly and legibly.

TO BE O.K'D BY Medical Examiner

C81006

C81006

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903.0

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) THERESA LAMB TAYLOR | N-821-0 |
| 2. DATE OF DEATH 12-19-49 | |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital | |
| c. Length of stay in Baltimore Yrs. Mos. Days | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore | |
| D. STREET ADDRESS (If rural, give location) 831 E. 33rd St. | 9-05 |
| 5. SEX F | 6. COLOR or RACE W |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) W | |
| 8. DATE OF BIRTH Oct. 1, 1857 | 9. AGE (In years last birthday) 92 yrs. If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10B. KIND OF BUSINESS OR INDUSTRY at home |
| 11. BIRTHPLACE (State or foreign country) Annapolis, Md. | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Andrew Lamb | 14. MOTHER'S MAIDEN NAME Mary |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO none |
| 17. INFORMANT Mr. George W. A. Taylor | ADDRESS 831 E. 33rd St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Intertrochanteric Fracture, rt. femur — 9 days

DUE TO

CERTIFICATION APPROVED BY

R B Fisher

(C) _____ M. D.

CHIEF OR ASST. MEDICAL EXAMINER.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Arteriosclerosis, Uremia

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) accident | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 831 E. 33rd Street |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-10-49 3 m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? Slipped while getting in bed |

22. *I hereby certify that I attended the deceased from* 12-10- , 1949, *to* 12-19- , 1949, *that I last saw the deceased alive on* 12-19- , 1949, *and that death occurred at* 6:20 A.M., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE Wa Wiemann M. D. | 23B. ADDRESS University Hospital | 23C. DATE SIGNED 12-19-49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/22/49 | 24C. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem. | 24D. LOCATION (City, town, or county) Annapolis, Md. | (State) |
| DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR WM. J. TICKNER & SONS | ADDRESS Balto., Md. | |

Wiemann

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G81007 ✓ G81007

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

81

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) VIRGINIA L. HAGAN

2 DATE OF DEATH Dec. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Methodist Home for the Aged 2211 W. Rogers Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2211 W. Rogers Ave. 27-15

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widow | July 5, 1867 | 82 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - | - | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Henry Slicer Lawson | Virginia S. Laudeman |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Miss Miriam O. Coates 2211 W. Rogers Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Bladder — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 18 Months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 12, 1949, *to* Dec. 18, 1949, *that I last saw the deceased alive on* Dec 18, 1949 *and that death occurred at* 9.01A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Arthur J Dawes M.D. | 800 N 33rd St. | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Greenmount Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams M.D. | W. J. TICKNER & SONS | Balto., Md. |

VS-158

52B

PLEASE WRITE PLAINLY WITH UNFADING INK. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C8:008

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 15

C8:008

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ETHEL BLANCHE KAY

2. DATE OF DEATH DEC 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. JOSEPH'S HOSP.

c. Length of stay in Baltimore 8 YRS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 3529 GOUGH ST

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | WIDOWED | 9/8/1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | Self | PENNSYLVANIA | |

13. FATHER'S NAME Amos Hess

14. MOTHER'S MAIDEN NAME Lorinna Houck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT HOSPITAL RECORDS ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) RHEUMATIC CARDIO VASCULAR DISEASE WITH AURICULAR FIBRILLATION AND

DUE TO

(B) MULTIPLE EMBOLIZATION

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/7/49 19__, *to* 12/18/49 19__, *that I last saw the deceased alive on* 12/18/49 19__. *and that death occurred at* 10:05 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE Thaddeus Slusiski M. D.

23B. ADDRESS St. Joseph's Hosp.

23C. DATE SIGNED 12/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Removal

24B. DATE 12/20/49

24C. NAME OF CEMETERY OR CREMATORY Dudley Pa.

24D. LOCATION (City, town, or county) (State) Penna

DATE RECEIVED BY LOCAL REGISTRAR DEC 19 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Cook Inc ADDRESS 1217 St Paul St

92c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly as far as known. Age is especially important. Physicians: please write the cause of death clearly and legibly.

G81003

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

421.0

G81003

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Marie Huebel (Hybl)

2. DATE OF DEATH: Dec. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bon Secours Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-03
D. STREET ADDRESS (If rural, give location): 801 N. Patterson Pk Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F. | W. | Widowed | 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Czechoslovakia | |

13. FATHER'S NAME: Joseph Vacheck

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Marie Marak | 801 N Patterson Pk |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Multiple Emboli

DUE TO

(B) Fibrillating Heart - Mitral Stenosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Arteriosclerotic - Hypertensive Cvd

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Coronary Sclerosis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 29, 1949 *to* Dec. 12, 1949 *that I last saw the deceased alive on* Dec. 17, 1949, *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| D. S. Snohler M. D. | Bon Secours Hosp | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-49 | Oak Hill | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 19 1949 | Huntington Williams, M.D. | Frank Graebener Son | 900 N Eutaw |

92B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68:040

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 2nd. 1

Registered No. 68:040

DISTRICT NO.

1. NAME OF DECEASED (Type or Print) Duncan, William Milne

2. DATE OF DEATH 12-17-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinecrest Sanitorium 600 South Chapelgate Lane

C. Length of stay in Baltimore 32 yrs Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 20-04
D. STREET ADDRESS (If rural, give location) 138 Landwehr Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | 4-26-1871 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | none | Scotland | U.S.A. |

13. FATHER'S NAME Andrew G. Duncan

14. MOTHER'S MAIDEN NAME Grace W. Milne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Elizabeth M. Duncan ADDRESS 138 Landwehr Lane

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis and Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C) Generalized arteriosclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Alcoholism, Chronic — 50 years.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* December 9, 1949, *to* 12-17-, 1949 *that I last saw the deceased alive on* 12-16-, 1949, *and that death occurred at* 1:37 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden, M. D. | 2030 W. Fayette St | 12/17/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Lorraine | Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Dorothy Williams, M.D. | Wm Cook Inc. | 217 St. Paul St |

VS 150

937

68162 BALTIMORE CITY HEALTH DEPARTMENT 68162

# CERTIFICATE OF DEATH 59

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNETTA W. ICEMAN

2. DATE OF DEATH Dec. 19, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2075 Rockrose Ave. Ardleigh Nursing Home

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,

D. STREET ADDRESS (If rural, give location) 720 Deepdene Road 27-13

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | June 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Koethe | (Unknown) Moeller |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Charles E. Iceman | 720 Deepdene Road. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Terminal Stroke DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 yr

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan 30 19 44 to Dec 19 19 49, that I last saw the deceased alive on Dec 19 19 49, and that death occurred at 6 a.m. from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm C Houck M. D. | 2904 W Mt Royal | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Baltimore | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

1218

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Information must be complete and correct age is especially important.

C8012 ✓ 420.0 C8012

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) SOPHIA K. TOWNSEND

2. DATE OF DEATH Dec. 19, 1949

3. PLACE OF DEATH Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 214 Ridgewood Road.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2501 Roslyn Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Aug. 27, 1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At. Home | Baltimore, Md. | |

13. FATHER'S NAME Otto Duker

14. MOTHER'S MAIDEN NAME Anna Radeke

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | None | Mrs Charles T. Mitchell | 214 Ridgewood Road |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Arteriosclerotic Heart disease | 3 y |
| ANTECEDENT CAUSES | DUE TO | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) DUE TO | Hemiplegia Rt. | 3 y |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 1-1-, 1946 *to* 12-19-, 1949, *that I last saw the deceased alive on* 12-18-, 1949, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Howard W. Warren M. D. | 2604 Garrison Blvd | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | National | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | William Took, Inc., | 1217 St. Paul St. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as directed on the other side. Items 1 to 17 and 23 to 25 are required. Item 18 must be completed as far as possible. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

9-D

68:013

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E903.6 1-8032

Registered No. 68:013

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GEORGE L. STEWART

2. DATE OF DEATH: December 18, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 666 W. Baltimore Street 4-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 6/1/1949 | 37 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: George A. Stewart
14. MOTHER'S MAIDEN NAME: Julia Horseman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife ADDRESS: 666 W. Baltimore Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial and cerebral hemorrhage
DUE TO (Fractured skull and subdural hematoma)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) Idiopathic epilepsy

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Saloon
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 700 W. Fayette Street 4/2
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): December 18, 1949 2 A m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Fell and struck head against radiator

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23a. SIGNATURE: R B Fraher M.D.
23b. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23c. DATE SIGNED: 12-19-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/21/49
24c. NAME OF CEMETERY OR CREMATORY: Green Lawn
24d. LOCATION (City, town, or county) (State): Cambridge Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm Cook Inc ADDRESS: 1217 E. Paul St.

VS 151

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered correctly and legibly. Physicians: please write the cause of death clearly and legibly.

68103

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

68104

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): Olga (Juanita) Graham. 432146
2. DATE OF DEATH: DEC 19 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY
c. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 416 N. Exeter St.
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.
8. DATE OF BIRTH: 3-28-17
9. AGE (In years last birthday): 32 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10B. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Graham
14. MOTHER'S MAIDEN NAME: Martha Serfferger
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Kimmelstiehl-Wilson's Disease — INTERVAL BETWEEN ONSET AND DEATH: ? 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Diabetes Mellitus — 23 yrs.

DUE TO

(C) —

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Hyperthyroidism, Diffuse — 3 yrs.

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): —
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 9-10- 1949 to 12-17- 1949, that I last saw the deceased alive on 12-17- 1949 and that death occurred at 12 05 Hm., from the causes and on the date stated above.

23A. SIGNATURE: Robert C. Hartmann M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 12/19/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/21/49
24C. NAME OF CEMETERY OR CREMATORY: Green Mount
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 20 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Wm Cook Jr. 217 St. Paul St.

VS 150

61

Please write the causes of death clearly and legibly. Physician: please write the cause of death clearly and legibly. Important. Physician: please write the causes of death clearly and legibly.

G81015

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81015

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) PHILIP PEDONE

2. DATE OF DEATH Dec. 16, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1103 Poplar Grove St.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1103 Poplar Grove St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Apr. 21, 1861 | 88 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | Fruit | Italy | |

13. FATHER'S NAME Philip Pedone

14. MOTHER'S MAIDEN NAME Augusta ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | none | Mr. Samuel Pedone | 1103 Poplar Grove |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocarditis, Arteriosclerosis | Dec 9 1949. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Dilatation of Aorta General Arteriosclerosis | ✓ |
| DUE TO (C) | Salvarsan | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| ns | none | none |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — | ✓ | ✓ |

22. *I hereby certify that I attended the deceased from* Dec 9, 1949 *to* Dec 16, 1949 *that I last saw the deceased alive on* Dec 16, 1949, *and that death occurred at* 8.45 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter A. Packard, M. D. | 1219 Eutaw Place | 12/18/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92 D

Please write plainly. Be sure that the cause of death is correctly stated. Physicians: please write the causes of death clearly and legibly. Be sure that the age is especially important.

G810:6

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

5 13

Registered No.

G810:6

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elden Sarah Huber

2. DATE OF DEATH Dec. 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR [redacted] (If not in hospital or institution, give street address or location) St. Joseph's

C. Length of stay in Baltimore 35 yr. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Prince George
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Laurel
D. STREET ADDRESS (If rural, give location) 320 Carroll Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | Married | January 7 1900 | 49 | 5 | 22 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wife.

10B. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (State or foreign country) Trenton, N. J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Johnson Lucas

14. MOTHER'S MAIDEN NAME Ellen Hogan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Earl V. Hosier ADDRESS Laurel Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Surgical shock — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Carcinoma

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Dec. 19, 1949 | Chronic sinusitis | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 18, 1949 *to* Dec. 19, 1949, *that I last saw the deceased alive on* Dec. 19, 1949, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James J. Mace M. D. | 1400 N. Caroline St. | Dec. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 22-1949 | | Laurel Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Francis Gosch Sons | Hyattsville Md |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

104B

G81017

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151 Registered No.

G81017

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPHINE M. VOJIK

2. DATE OF DEATH Dec. 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2216 Ashland Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore 60 yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 2216 Ashland Ave. 7-23

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | April 20, 1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Czechoslovakia | U.S. |

13. FATHER'S NAME: Joseph Petr

14. MOTHER'S MAIDEN NAME: Mary Charvat

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Frank Vojik, husband | 2216 Ashland Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cholelithiasis, Ca gall bladder,
DUE TO Stomach, liver, lymph glands.
(B) Pernicious Anemia
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION 9-15-49 | 19B. MAJOR FINDINGS OF OPERATION Gall stones, Ca gall bladder | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, to 12-16-49, *that I last saw the deceased alive on* 12-1-49 *and that death occurred at* 6 p *m., from the causes and on the date stated above.*

23A. SIGNATURE Fred Hunter M. D. | 23B. ADDRESS 600 N Wolfe St | 23C. DATE SIGNED 12-19-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 20, 1949 | Holy Redeemer Cem. | 4430 Belair Rd. Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR DEC 20 1949 | REGISTRAR'S SIGNATURE Huntington Williams, M.D. | 25. FUNERAL DIRECTOR AND ADDRESS: Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St.

VS 150

462

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G8:0:8

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4-20-1

G8:0:8

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): ANNIE M. STISSEL

2. DATE OF DEATH: Dec. 18th, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 321 N. Payson Street

c. Length of stay in Baltimore: life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 321 N. Payson Street 20 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Oct. 6th, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Balto., Md. | USA |

13. FATHER'S NAME: Harry G. Frisch

14. MOTHER'S MAIDEN NAME: Kate Wooden

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | none | H. A. Stissel, 4205 Fullerton Ave., Balto. 6 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis Myocarditis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Complete Coronary Occlusion — DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Jan 1 *20*, 1948 *to* Dec 18, 1949, *that I last saw the deceased alive on* Dec 18, 1949, *and that death occurred at* 2 *20* p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Kadow M. D. | 2306 Eutaw Pl | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Dec. 21, 1949 | Woodlawn | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams M.D. | Lonahan Funeral Home | 7401 Belair Rd. |

VS 150

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68:019

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 68:019

1. NAME OF DECEASED (Type or Print): MAUDE L. STEVENS.

2. DATE OF DEATH: Dec 18, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3035 Huntingdon Ave.

c. Length of stay in Baltimore Life 38 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12-07
D. STREET ADDRESS (If rural, give location): 3035 Huntingdon Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | white | Widowed | Nov 30 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | — | Pennsylvania | U.S. |

13. FATHER'S NAME: Phillip Rotterman

14. MOTHER'S MAIDEN NAME: Martha Blankburger.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Georgia F. Martin - 3035 Huntingdon Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Endocarditis — (Interval between onset and death) 10 yrs

DUE TO

(B) Chronic Interstitial Nephritis — 10 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov 25, 1949 *to* Dec 18, 1949, *that I last saw the deceased alive on* Dec 17, 1949, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. A. Parks M.D. | 3017 Maryland Ave | Dec 18 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 21 49 | Lorraine Park | Windsor Mill Rd Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Austin E. Donovan | 3818 Gland ave |

VS 150

1310

(G81020)

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4 4 ✓ G81020

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN EDWARD BROMWELL

2. DATE OF DEATH: Dec. 18, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3038 E. Baltimore St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3038 E. Baltimore St. E-21

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | April 17, 1872 | 77 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired packer | wholesale notions | Baltimore, Md. | |

13. FATHER'S NAME: John E. Bromwell

14. MOTHER'S MAIDEN NAME: Hester Tall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mrs. Camilla Millikin | 3038 E. Balto. St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute Cardiac Failure | 1 |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Cardiovascular Renal Disease | 5 yrs |
| | DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 11-10 1949, to 12-18, 1949 that I last saw the deceased alive on 12/18, 1949, and that death occurred at 12:10 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph L Lancaster M. D. | 679 Washington Blvd | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Deputy for Nathanson, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

131a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81021

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4343

Registered No. G81021

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALBURGA F. DUERR

2. DATE OF DEATH 12-19-49

3. PLACE OF DEATH: a. Baltimore City, Maryland 2706 Edmondson Av

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 61 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 2706 Edmondson ave. 16-06

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | w | widowed | 5-19-1861 | 88 | 7 | — | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none. | | Germany. | U.S. |

13. FATHER'S NAME Jerichaal Knorr

14. MOTHER'S MAIDEN NAME Anna ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | — | Anna C. Burger | 2706 Edmondson av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Organic Heart Disease | at least 10 years |
| DUE TO (B) | — | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | — | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | — | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 1- , 1939, to 12-19- , 1949, *that I last saw the deceased alive on* 12-19-49 49 *and that death occurred at* 1:00 P *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Chester Riland M. D. | 2532 Edmondson Ave | 12-19-49. |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12/22/49 | HOLY REDEEMER | BALTIMORE |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | JOHN T. STANSBURY | 2700 EDMONDSON AVE. |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO. 22

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 68:022

1. NAME OF DECEASED (Type or Print): Frank P Reynolds
2. DATE OF DEATH: 12-15-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 300 Worsley St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 300 Worsley St. 12 04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Col. | Married | Sept. 12 1881 | 68 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Howard Co. Md. | U.S.A. |

13. FATHER'S NAME: Robert Reynolds
14. MOTHER'S MAIDEN NAME: Julia Parker

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. | | Bessie Reynolds | 300 Worsley St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary thrombosis
DUE TO
(B) arteriosclerosis
DUE TO
(C) Diabetes Pneumonia

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from Nov 26, 1949, to Dec 15, 1949, that I last saw the deceased alive on Dec 14, 1949, and that death occurred at ____ m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lawrence Johnson M.D. | 2329 Guilford Ave | Dec. 20 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-1949 | West Liberty Cem | Howard Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Timberlake Williams, M.D. | Mrs Katie R. Williams | 521 N Stricker St |

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81023

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

466 G81023 Registered No.

1. NAME OF DECEASED (Type or Print): WILLIE WILLIAMS

2. DATE OF DEATH: December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. 18 Mos. Days 02

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1053 W. Lexington Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | July 28, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Labour | | Fayettesville N. | U.S.A. |

13. FATHER'S NAME: Britt Williams

14. MOTHER'S MAIDEN NAME: Alice

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Bessie L. Williams | 1063 W. Lexington |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction of lung

DUE TO

(B) Pulmonary embolism

DUE TO

(C) Primary Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George S. Mervis M.D. | | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Shipped | 12-20-1949 | Fayettesville N.C. | Fayettesville N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 322 N Schroeder St |

VS 151

100 B

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

81034 ✓ 681024

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No.

1. NAME OF DECEASED (Type or Print): Melkiah Howard

2. DATE OF DEATH: DEC 17-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1909 Sapp St

c. Length of stay in Baltimore: 40 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1909 Sapp St 9 08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | Married | 2/18/1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Virginia | U.S. |

13. FATHER'S NAME: Jack Howard

14. MOTHER'S MAIDEN NAME: Jane

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Dasey Howard | 1909 Sapp St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 16 1949, to Dec 17, 1949, *that I last saw the deceased alive on* Dec 16, 1949, *and that death occurred at* 4 30 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Stanford A. Snowden M.D. | 2309 Druid Hill Ave. | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-20-49 | Mt Calvary | A.A. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Rayner Sanders | 830 1412 E. Preston St |

VS 150

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81025

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

490 G81025 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): **Daisy Taylor**

2. DATE OF DEATH: **Dec. 18, 1949**

3. PLACE OF DEATH: **X** Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): **617 W. Mulberry St.**

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: **Maryland**
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): **Baltimore**
D. STREET ADDRESS (If rural, give location): **617 W. Mulberry St.** 402

5. SEX: **Female**
6. COLOR OR RACE: **Colored**
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): **Married**
8. DATE OF BIRTH: **Nov. 10, 1901**
9. AGE (In years last birthday): **48** (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Housewife**
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): **Virginia**
12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME: **Peter Brickhouse**
14. MOTHER'S MAIDEN NAME: **Nellie Topman**

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: **Mr. Alexander Taylor** ADDRESS: **617 W. Mulberry St**

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) **Lobar Pneumonia** — INTERVAL BETWEEN ONSET AND DEATH: **10 days**
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) **Malnutrition**

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 11/1 49 *to* Dec 18 49, *that I last saw the deceased alive on* Dec 18 49, *and that death occurred at* 2:00 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: **Wm Gaines** M. D.
23B. ADDRESS: **253 Cross St**
23C. DATE SIGNED: **12/20/49**

24A. BURIAL, CREMATION, REMOVAL (Specify): **Burial**
24B. DATE: **12-21-49**
24C. NAME OF CEMETERY OR CREMATORY: **Mt. Auburn Cem.**
24D. LOCATION (City, town, or county): **Baltimore** (State): **Md.**

DATE RECEIVED BY LOCAL REGISTRAR: **DEC 20 1949**
REGISTRAR'S SIGNATURE: **Huntington Williams, M.D.**
25. FUNERAL DIRECTOR: **Mastranuono & Hensley** ADDRESS: **518 W. Biddle St**

VS 150

108

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81026

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 20 1

G81026 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ENOCH L. WEAVER

2. DATE OF DEATH December 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1133 Sarah Ann Street

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
C. STREET ADDRESS (If rural, give location) 1133 W. Lafayette Street 16 0 2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| M | C | ✓ | May 19, 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or Foreign Country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Labor odd jobs. | Labor. | Newbern, N.C. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Curran T. Weaver | Dorsey Eliza Fulton |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Susie Hamm 2430 Madison Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary art ry thrombo
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Royer M.D | | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Ft. Auburn. | Balto, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Holland Funeral Home | 1631 Druid Park |

VS 151

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81027

G81027

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Fitchett 488211

2. DATE OF DEATH: 12-18-49

3. PLACE OF DEATH: a. Baltimore City, Maryland Balto City

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 529 N. Bond St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | Colored | M. | 11-5-04 | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at Home | Baltimore | U.S.A. |

13. FATHER'S NAME: Jerry Hall

14. MOTHER'S MAIDEN NAME: Sarah Stevens

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis & Uremia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Duration unknown

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Orrok, M. D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-22-49 | Arbutus Mem. | Arbutus Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Hunter for Williams, M.D. | Elroy O Wilson | 1000 Brantly ave |

VS 150

131a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

68:1028

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

68:1028

STATE NO.

Registered No.

1. NAME OF DECEASED (Type or Print) George Adam Nissell

2. DATE OF DEATH 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2802 Westfield Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2802 Westfield Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Jan 29 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Hardware Merchant | Balto Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Adam Nissell | Katherine Mueller |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Helen Nissell 2802 Westfield Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Coronary occlusion, acute | a1 days |
| | DUE TO | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | | |
| | DUE TO | | |
| | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* December, 1949, *to* December 18, 1949, *that I last saw the deceased alive on* June 10, 1949, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ronald Jandorf M.D. | 6077 Harford Rd | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 18 1949 | Woodlawn | Woodlawn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Linthicum Williams, M.D. | Henry Kunsberg | 4204 Ridgewood Ave |

VS 150

94a

Correct age is especially important. Physicians: please write the name of disease clearly and legibly.

G81023

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81023

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Salvatrice (Avvico) Avvigo

2 DATE OF DEATH 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore 50 Yrs. Days

4. USUAL RESIDENCE (Where deceased lived If institution: reside prior to admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RFD, and give township) Baltimore
D STREET ADDRESS (If rural, give location) 417 East Street

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED WIDOWED DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| F | W | M | | 73 | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | ITALY | U.S. |

13. FATHER'S NAME Anthony Moreci

14 MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT ADDRESS |
|---|---|---|
| no | | Vincent Bruga 5582 Belair Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
(A) Myocardial Infarction
DUE TO
Coronary Thrombosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | yes ☑ no ☐ |

| 21A ACCIDENT, SUICIDE HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give street location) |
|---|---|---|
| | | |

| 21D TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E INJURY OCCURRED | 21F HOW DID INJURY occur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22 *I hereby certify that I attended the deceased from* 12/16 1949 *to* 12/19 1949, *that I last saw the deceased alive on* 12/17 1949, *and that death occurred at* 8 a 12/19/49 *from the causes and on the date stated above.*

| 23A SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Max J Miller M.D. | Sinai Hosp. | 12/19/49 |

| 24A BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | Dec. 22 1949 | Holy Redeemer Cemetery | 3340 Belair Rd. Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 20 1949 | Lurington Williams, M.D. | Joseph Lanza Inc 2013 Guilford Ave |

VS 150

94a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81030

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81030

STATE NO.

1. NAME OF DECEASED (Type or Print) David Stanley Musgrove Sr.

2. DATE OF DEATH December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 5032 Gwynn Oak Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) —

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5032 Gwynn Oak Ave. 28 02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Nov. 24, 1891 | 58 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Contractor | Floor Business | Maryland. | U.S.A. |

13. FATHER'S NAME Charles Musgrove

14. MOTHER'S MAIDEN NAME Laura Easton.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | 578-05-4935 | Mrs Flore V. Musgrove | 5032 Gwynn Oak |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Jan 1946 to Dec 18, 1949, that I last saw the deceased alive on Dec 18, 1949, and that death occurred at 7 P. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leonard S. Kaelin M. D. | 1847 N. North Ave | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 22/49 | Mt. Olivet | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Young & Eyers | 3005 W. Fayette Ave |

VS 150

94a

Correct age is especially important. Physician: please write plainly with pen and ink. Do not abbreviate.

# CERTIFICATE CORRECTED 12-28-49 VS

G81031

G81031

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frederick A. Sigmund

2. DATE OF DEATH December 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5011 Elmer Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 5011 Elmer Ave 27-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 31 1877 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Supervisor | U.S. Post Office | Phila. Pa. | U.S.A. |

13. FATHER'S NAME William H. Sigmund

14. MOTHER'S MAIDEN NAME Martha Wilson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Anna E. Sigmund | 5011 Elmer Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Cardio-vascular disease — Abt 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 8 48, 19__, to Dec 18, 1949, *that I last saw the deceased alive on* Dec 17 49 19__, *and that death occurred at* 10 24 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter S. Tilbett M. D. | 2220 Harrison Blvd | Dec. 19 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) ADDRESS |
|---|---|---|---|
| Burial | December 21 49 | Druid Ridge | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| DEC 20 1949 | Huntington Williams M.D. | Loring Byers 5005 Park Heights Ave |

VS 150

92D

G81032

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 983. G81032

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) GEORGE THOMAS — N-85[illegible]2

2. DATE OF DEATH December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 588 Baker Street 14-C-3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | S. | 6/1/1923 | 26 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | None | Balto. Md. | U. S. A. |

13. FATHER'S NAME Aquilla Thomas

14. MOTHER'S MAIDEN NAME Elizabeth Trent

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | ? | Elizabeth T. Thomas | 588 Baker St. |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Intracranial hemorrhage | |
| DUE TO | | |
| (B) | Fracture of nose | |
| DUE TO | | |
| (C) | Contusion of scalp | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Other conditions--Acute alcoholism

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Public -- street | 1346 Woodyear Street in front of |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 12-18-49 About 10 p.m. | | Multiple impacts to head during altercation |

22 *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| George S. Messick M.D. | | Dec. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | St Peters Cemetery | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | [illegible] for Williams, M.D. | Geo. G. Nelson | 1303 Presstman St. |

VS 151

168

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Caroline A. Schafer

681033

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 681033

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Caroline Schafer

2. DATE OF DEATH: Dec. 14-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 637 W. Conway St.

C. Length of stay in Baltimore: Life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 637 W. Conway St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White. | | Apr. 27-1857 | 92 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | At Home | Baltimore - Md | U.S. |

13. FATHER'S NAME: Henry R. Schafer

14. MOTHER'S ~~MAIDEN~~ NAME: Margaret ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | None | Mrs. M. Willhouck | 456 Brunswick St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteri-Sclerotic C. V. Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| — | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | | 15 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 20/49 | Loudon Park | Baltimore - Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | J. B. Wippert & Son | 1300 Eutaw Pl. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G81034

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

60.0

G81034

Registered No.

BIRTH NO. 49-27403

1. NAME OF DECEASED (Type or Print): Alphonzo Michael Gaskins

2. DATE OF DEATH: December 1, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital

c. Length of stay in Baltimore: 2 days (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2702 Bookert Drive

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Negro | | Nove. 28, 1949 | | | 2 | 10 | 35 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| John Harris | Agnes Gaskins |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| | | The Johns Hopkins Hospital | 601 N. Broadway |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intracranial Hemorrhage

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Rapid Labor

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nove. 28, 1949 *to* Dec. 1, 1949 *that I last saw the deceased alive on* Dec. 1, 1949, *and that death occurred at* 8:34 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| W. Andrews M. D. | 601 North Broadway | 12-8-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Bon Secours | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, MD | | |

VS 150

160a

Correct age is especially important — Please do not write above or below lines — Type or use pen and ink — Do not use pencil

G81035

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

Registered No. G81035

1. NAME OF DECEASED (Type or Print) GEORGE SIMONS

2. DATE OF DEATH December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Mercy Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 274 N. Exeter St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | colored | | 1-4-1901 | 48 sml | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Georgia | |

13. FATHER'S NAME
?

14. MOTHER'S MAIDEN NAME
Ella Simmons -274 N. Exeter St.

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage
DUE TO
(B) Spontaneous
DUE TO
(C) Hypertensive C. V. Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Dec. 19, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Balto. National Cemetery | Balto. Maryland |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Walter B. Griggs | 139 E. Hamburg St. |

VS 151

92

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81036 PIKARSKI ✓ G81036

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 51 Registered No.

1. NAME OF DECEASED (Type or Print) MATEUSZ PIKARSKI

2. DATE OF DEATH Dec 20 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 750 S. Castle St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 250 S Castel St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | - | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | — | Poland | |

13. FATHER'S NAME Unk.

14. MOTHER'S MAIDEN NAME Unk

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT Mary Kurgan ADDRESS 250 S Castel St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Squamous Epithelioma with Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) Myocarditis Arteriosclerosis — 6 yr

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* Dec 6, 19 49 *to* Dec 20, 19 49 *that I last saw the deceased alive on* Dec 6, 19 49, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Carl Kemper M.D. | 750 S Castle St | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 23/49 | Holy Cross | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Fred W. Ozazewski | 1930 Eastern Ave. 46B |

VS 150

CERTIFICATE CORRECTED 12/27/49

68 1037

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 980

68 1037

Registered No. N-96810

BIRTH NO. H-079441

1. NAME OF DECEASED (Type or Print) FRANCIS KOWALESKI (Francis Kowalski)

2. DATE OF DEATH Dec 18 49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2011 Ashland.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 7-0

D. STREET ADDRESS (If rural, give location) 2011 Ashland Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | Sept 1 1944 | 5 | 3 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | — | Baltimore | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Kowalski | Henrietta Plotczyk |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | | | Frank Kowalski | 2011 Ashland Ave |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Asphyxiation | |
| | DUE TO carbon monoxide poisoning | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2011 Ashland Ave. |
|---|---|---|
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 17, 1949 11 Pm | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY Ooccur? Four burners of range on but unlit |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L Ruzicka M.D | | 18 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Dec. 21/49 | [illegible] Cemetery | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams M.D | Fred W Ozazewski | 1930 Eastern Ave |

VS 151

168

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE CORRECTED 12/27/49

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

F 972. F 968:0

Registered No. 681038

681038
BIRTH NO.

KOWALESKI

1. NAME OF DECEASED (Type or Print) Henrietta Kowalski

2. DATE OF DEATH Dec 16 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2011 Ashland Ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2011 Ashland Ave. 7-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Jan 30 1922 | 27 | 11 | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Baltimore | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Elsie

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Frank Kowalski | 2011 Ashland Ave |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Asphyxiation | |
| DUE TO | carbon monoxide poisoning | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) Despondency | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 2011 Ashland Avenue |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ | NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| Dec. 18, 1949 11 P m. | | | (illuminating gas) Four burners of range on but unlit |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Paul L Ryan M.D. | ☒ | 18 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Dec 21/49 | Holy Rosary | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Fred W Ozazewski | 1630 1930 Eastern Ave |

VS 151

correct age is especially important. Physician: please write the cause of death clearly and legibly.

681039

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. 681039

1. NAME OF DECEASED (Type or Print): CARRIE COX

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27 N. Carey St. Good Samaritan Home
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 116 N. Janney St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Mar. 23, 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Easton, Md. | |

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME: —

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mr Drews | 116 N. Janney St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CEREBRAL HEMORRHAGE | 3 WKS |
| DUE TO (B) | ARTERIOSCLEROSIS, GENERALIZED | 20 YRS. |
| DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* JAN. 1, 1949 *to* DEC. 20, 1949 *that I last saw the deceased alive on* DEC. 19, 1949 *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Dickerson M.D. | 121 S. HIGHLAND AVE | 12/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/20/49 | Spring Hill | Easton Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Fulton Shue | 1214 Fawn St |

VS 150

832

G81040

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

53.3 3 G81040

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY ARNOLD STARKEY

2. DATE OF DEATH: Dec. 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2441 E. Biddle St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 12/23/05 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Ordinary seeman | Seafarer | Md. | USA |

13. FATHER'S NAME: James Starkey

14. MOTHER'S MAIDEN NAME: Sallie Hughes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Unknown | 220-05-4152 | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia, Aspiration | 4-5 days |
| DUE TO (B) | Atelectasis | 4 wks. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Epilepsy | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/13/48 | Craniotomy- evidence of pressure found. Pressure relieved. | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Aug. 30, 1948, *to* Dec. 18, 1949, *that I last saw the deceased alive on* Dec. 18, 1949 *and that death occurred at* 11:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W B Ramsey M. D. | US Marine Hospital, Balto, Md. | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 22-49 | Oak Lawn | Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | John F. Connelly | Essex |

VS 150

107

G8104 1 G8104

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 20

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dorsey Louis Baker
2. DATE OF DEATH: Dec 18 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland: 3402 Edmondale Av
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): No.
c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
A STATE: 3402 Edmondale Av
B COUNTY: Baltimore Md.
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md.
D STREET ADDRESS (If rural, give location): 3402 Edmondale Av 12-19-49

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | Feb. 23 - 1867 | 82 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Insurance agent | Seneca Co Md | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Baker | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Lillian M Baker (wife) | 3402 Edmondale Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 1 hr |
| DUE TO (B) | Arterio Sclerosis Hypertension | 1 yr. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Chronic Interstitial Nephritis | 1 yr. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 15 1949, *to* Dec 18, 1949, *that I last saw the deceased alive on* Dec 17, 1949, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. A. Strauss M. D. | 2878 Harford Rd | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | Providence Meth | Kemptown Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Leonard J Luck | 5305 Harford Av |

VS 150

12/a

G81032

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No.

G81032

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alfred Hoggard

2. DATE OF DEATH: 12/17/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. CIty Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: 25 yrs (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1137 Penna. Av. 17-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Widowed | 6/1/1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Storekeeper | Grocery Bus. | N.C. | U.S.A. |

13. FATHER'S NAME: Heat

14. MOTHER'S MAIDEN NAME: Catherine

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Hezekiah Hoggard (B) | Rt. #1 Box 22 Eliz. City, N.C. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V. Disease — DUE TO

(B) — DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy / Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L Beyer M.D. | | 18 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Huntington Williams, M.D. | Chas. H. Corpe Sr | 512 Cancelton Av. |

VS 151

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81033 ✓ G81033

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 443

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. JOHN E. ROHLEDER

2 DATE OF DEATH: 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DON SECOURS HOSPITAL
c. Length of stay in Baltimore: life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 754 W. Hamburg St.

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| M | W | SINGLE | 7/2/77 | 72 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Proprietor | Electrotype Co. | MARYLAND | U. S. A. |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| John B. Rohleder | Mary F. Klich |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| no | 212-07-2863 | Mrs. Emma R. Ripper | 44 Melvin Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 17 DAYS

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) HYPERTENSIVE C.V.D.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22 *I hereby certify that I attended the deceased from* DEC. 19, 1949 *to* DEC. 19, 1949 *that I last saw the deceased alive on* DEC. 19, 1949, *and that death occurred at* 7:13 ~~P~~ A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Paul O. Mannix M. D. | Bon Secours Hospital | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Cathedral Cem. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 20 1949 | Winston for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

92D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81034

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 210 G81034

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | LILY C. ALBERT |
| 2. DATE OF DEATH | Dec. 19, 1949 |
| 3. PLACE OF DEATH: A. | Baltimore City, Maryland |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2707 Elsinor Ave. |
| C. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 2707 Elsinor Ave. |
| 5. SEX | female |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | widowed |
| 8. DATE OF BIRTH | July 24, 1872 |
| 9. AGE (In years last birthday) / If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min. | 77 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | housewife |
| 10B. KIND OF BUSINESS OR INDUSTRY | at home |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | William E. Mason |
| 14. MOTHER'S MAIDEN NAME | Cornelia Burke |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | no |
| 17. INFORMANT / ADDRESS | Mrs. J. Frank Hilit 2707 Elsinor Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Nitrate Stenosis

DUE TO

(C) Hemorrhage — 17 hrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur? |

22. *I hereby certify that I attended the deceased from* ____, 1949 *to* Dec 19, 1949 *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| [illegible] M.D. | 313 Cleaver St Balto 12 | Dec 20/49 |

| | | | | |
|---|---|---|---|---|
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) | |
| Burial | 12/22/49 | Balto. Cem. | Balto., Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS | |
| DEC 20 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. | |

VS 150

926

C81045 X ✓ 420.1 C81045

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MARY B. OPENSHAW

2. DATE OF DEATH December 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parkton
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | Married | April 3, 1882 | 67 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Balti. Co. Md. | |

13. FATHER'S NAME Wm. Matthews

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Mrs. Lemuel Jones Parkton, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Emil L Beyer M.D. | | Dec. 20, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 23 1949 | Pine Grove E.U.B. | Bayville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 20 1949 | Washington Williams, M.D. | J. Jacob Hardesty 94a New Freedom, Penna. |

VS 151

correct age is especially important. If uncertain, give best estimate and so state. Space for remarks is on reverse side.

C81046 ✓ 160 C81046

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-22599 Registered No.

1. NAME OF DECEASED (Type or Print): BABY JULIANA SMITH

2. DATE OF DEATH: 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BON SECOURS HOSPITAL
c. Length of stay in Baltimore: Yrs. — Mos. — Days 2

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 16 07
D. STREET ADDRESS (If rural, give location): 1341 Poplar Grove St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | S | 10/21/49 | | 1 28 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE. | | MARYLAND | |

13. FATHER'S NAME: MR. W. HUGH SMITH

14. MOTHER'S MAIDEN NAME: JULIANA HANCOCK

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | None | W HUGH SMITH | 1341 Poplar Grove St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) POST-OPERATIVE SHOCK, & RESPIRATORY FAILURE

DUE TO

(B) PULMONARY ASPIRATION & ATALECTASIS

DUE TO

(C) CONGENITAL PYLORIC STENOSIS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/19/49, 19__, to DEC. 19, 1949 *that I last saw the deceased alive on* DEC. 19, 19 49 *and that death occurred at* 11:35P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul J. Manning M. D. | Bon Secours Hosp. | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | Mt. Olivet | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 20 1949

REGISTRAR'S SIGNATURE: Interim for Registrar Md

25. FUNERAL DIRECTOR: D. Howard Strong ADDRESS: 3207 W. North Ave.

VS 150

157E

Correct age is especially important. If unknown, please write the words "Unknown" and explain.

68107

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

171 Registered No. 68107

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Harr

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — a 3 n. Gyn.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS

c. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Washington
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerstown R.F.D. 3
D. STREET ADDRESS (If rural, give location):

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-3-48
9. AGE (In years last birthday): 51 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life. Never if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lewis Margan
14. MOTHER'S MAIDEN NAME: Mary Cromer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma cervix, metastasis to bladder,
DUE TO
(B) fistula because of necrosis and liver damage, following to operation,
DUE TO
(C) (Operation: cystotomy, bilateral implantation of ureters into sigmoid, ~~ureteral implantation to sigmoid~~ Colpectomy)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Postoperative recto-suprapubic fistula; increasing uremia up to death.

19A. DATE OF OPERATION: 10/25/49
19B. MAJOR FINDINGS OF OPERATION: cystotomy, bilateral implantation of ureters into sigmoid.
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19-, 1949 *to* 12-20-, 1949 *that I last saw the deceased alive on* 12-20-, 1949 *and that death occurred at* 4:05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Charles P. Leadbetter M. D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED: 12/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24D. LOCATION (City, town, or county) (State): Hagerstown, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Fred W. Evans, Hagerstown, Md. ADDRESS:

VS 150

48a

CERTIFICATE CORRECTED 12-22-49

C810:8

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420

C810:8

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): JOHN McMURRAY

2. DATE OF DEATH: December 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memoiral Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5126 Craig Avenue 27-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 27, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Foreman | Bendix Corp. | Baltimore, Md. | |

13. FATHER'S NAME: George T. McMurray

14. MOTHER'S MAIDEN NAME: Mary Langlotz

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W. I | | Mrs. Charlotte Leffingwell | 2514 Taylor Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Artery Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| Emil L. Rayle M.D. | | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 12/23/49 | Loudon Park | Baltimore | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, MD | Wilhelm & Son | 1217 E. Fort Ave |

VS 151

94a

G8:049 ✓ X Released for autopsy by coroner

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G8:049

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): William Oscar Williams

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Memorial Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Old Pimlico Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Single | about 1871 | 78 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unknown | Laura E. Williams |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Hammond | Pimlico Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary edema, acute.

DUE TO

(B) arteriosclerotic heart disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) mesenteric thrombosis, branch

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

left colic artery.

Nephrosclerosis

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles H. Watts, M. D. | Mercy Memorial Hospital | 12/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Presbyterian Lawn | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Wilson & Son | 1214 E. Lond St |

131a

68:050 ✓ 68:050

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 443 Registered No.

1. NAME OF DECEASED (Type or Print): Joseph Gaskel

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: 50 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 3924 Carlisle Ave. 15 09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | April 26 1884 | 65 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Russia | U.S.A. |

13. FATHER'S NAME: Haskel Gaskel

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Dr. JASON H. Gaskel ADDRESS (Same)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5½ hrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Arteriosclerotic Cardio Vascular disease

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/20, 1949 *to* 12/20, 1949 *that I last saw the deceased alive on* 12/20, 1949, *and that death occurred at* 6:40 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward H. Pancoast M. D. | Mercy Hospital | 12/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Oheb Shalom Cong. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Sol. Levinson & Bros. | 1124-26 W. North Avenue |

VS 150

93D

G8:0.51 ✓ G8:0.51

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 3 3 ✓ Registered No.

1. NAME OF DECEASED (Type or Print): SIMON LIEBERMAN

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levendale
c. Length of stay in Baltimore: 50 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-17
D. STREET ADDRESS (If rural, give location): Levendale

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | | 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Russia | |

13. FATHER'S NAME: Zelig

14. MOTHER'S MAIDEN NAME: Jessie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO:

17. INFORMANT: Hospital records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Thrombosis | 14 days |
| DUE TO (B) | Arteriosclerosis | years |
| ANTECEDENT CAUSES — I DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-20 *to* 12-20, 1949, *that I last saw the deceased alive on* 12-20, 1949, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Nagel M.D. | Levindale Home | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | Hebrew Herring Run | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

P3B

G81052 — BALTIMORE CITY HEALTH DEPARTMENT — G81052

# CERTIFICATE OF DEATH

BIRTH NO. 49-27899 — Registered No. 760

1. NAME OF DECEASED (Type or Print): BABY GIRL EDMOND "A"

2. DATE OF DEATH: DEC. 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
C. Length of stay in Baltimore: 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 644 W Fayette St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | single | Dec 15, 1949 | | | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| infant | | Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Christopher Palacovolla | Mrs Loretta Edmond |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain Damage

DUE TO

(B) Asphyxia Neonatorum

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 15 1949 *to* Dec 17, 1949 *that I last saw the deceased alive on* Dec 17 1949 *and that death occurred at* 10 10A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas Ludwig M. D. | University Hosp. | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 20 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

160a

G8:0:53 ✓ G8:0:53

BIRTH NO. 49-28577

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): BABY GIRL REED

2. DATE OF DEATH: 12-15-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: 4 ~~Yrs.~~ ~~Mos.~~ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 631 N. Saratoga St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Single | 12-11-49 | | | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| infant | — | Maryland | USA |

13. FATHER'S NAME: Henry Lee Hall

14. MOTHER'S MAIDEN NAME: Isabelle Reed

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) atelectasis

DUE TO

(B) prematurity

DUE TO

(C) prolonged congenital syphilis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-11, 1949 *to* 12-15, 1949, *that I last saw the deceased alive on* 12-15, 1949, *and that death occurred at* 12:25 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerome Lubin, M. D. | University Hospital | 12-15-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL DEC 20 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Lucius Williams, M.D. | Commissioner of Health | |

VS 150

30F

CERTIFICATE CORRECTED 12-28-49

B81054 B81054 B-81054

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) Henry F. Sommerman — 2. DATE OF DEATH 20 Dec 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital

c. Length of stay in Baltimore: life (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Raspeburg, Md.

D. STREET ADDRESS (If rural, give location) Box 499 Fitch Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | M | Feb. 8th, 1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Weigh Master | H.T. Campbell | Germany | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Daniel Sommerman | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. H.F. Sommerman | Fitch Ave. Box 499 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ca of bladder

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — post-operative death

DUE TO

(C) — 3 hrs - ? Coronary

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 29 NOV 1949, 20 Dec 1949 | Infiltrating Carcinoma of Bladder | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| NO | NO | NO |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| NO m. | WHILE AT WORK ☐ NO WHILE NOT AT WORK ☐ | NO |

22. *I hereby certify that I attended the deceased from* 20 Oct *1949 to* 20 Dec *1949, that I last saw the deceased alive on* 20 Dec. *19 49, and that death occurred at* 4:53 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irving Scherlis M. D. | Sinai Hospital | 20 Dec. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/23/49 | Parkwood | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | [illegible] Williams, M.D. | Lassahn Funeral Home | 7401 Belair Rd. |

VS 150

520

G81055

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81055

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JEREMIAH (JERRY) PHELPS NEWBERRY

2. DATE OF DEATH: Dec. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1411 Hollins St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1411 Hollins St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | widowed | July 29, 1897 | 52 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| salesman | | Plymouth, N. C. | |

13. FATHER'S NAME: Robert L. Newberry

14. MOTHER'S MAIDEN NAME: Lena Read

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 218-14-7196 | Miss Lois Newberry | 5600 Tramore Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 25, 1949 *to* Dec 19, 1949, *that I last saw the deceased alive on* Dec 19, 1949, *and that death occurred at* 7:45 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Milton Krasnow M. D. | 23B. ADDRESS: 1429 W Fayette St. | 23C. DATE SIGNED: 12/20/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Loudon Park Cem. | Balto., Md. |

DATE RECEIVED BY REGISTRAR: DEC 21 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: WILLIAM J. TICKNER & SONS | ADDRESS: Balto., Md.

VS 150

94a

881058

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. 881058

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LENA JENNINGS

2. DATE OF DEATH December 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Provident Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 815 Pennsylvania Avenue 17-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | colored | U | U | 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute pulmonary edema | |
| | DUE TO Hypertensive heart disease | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George A. Merrill M.D. | | Dec. 5, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL DEC 15 1949 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

93D

G81057

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 2 3

G81057

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GRACE PULLAN

2. DATE OF DEATH: December 5, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1614 E. Pratt Street 3-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | U | U | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | K | |

13. FATHER'S NAME: N O

14. MOTHER'S MAIDEN NAME: O

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Uremic Asphyxia

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Emil R. Boyd, M.D. | | 12-5-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 15 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

Correct age is apparently important. Hyperuric. Please write the names of death clerk and registry.

30

G81058

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G81058

1. NAME OF DECEASED (Type or Print): Anna D. Balassone

2. DATE OF DEATH: Dec 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 116 Edgewood St

c. Length of stay in Baltimore: 1 yr. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 116 Edgewood St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): Widow
8. DATE OF BIRTH: Oct 22 1876
9. AGE (In years last birthday): 73 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Sulmona, Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank LaRivista
14. MOTHER'S MAIDEN NAME: Mary Antinnarelli
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: No
17. INFORMANT: Frank D. Balassone ADDRESS: 1402 W. Lemmon

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1yr
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: 4/23/49
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of Sigmoid Colon
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/23/49, 19__, *to* 12/20, 1949, *that I last saw the deceased alive on* 12/20, 1949, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Walter K. Grindlay M.D.
23B. ADDRESS: 4209 Harford Ave
23C. DATE SIGNED: 12/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 23/49
24C. NAME OF CEMETERY OR CREMATORY: St Thomas'
24D. LOCATION (City, town, or county) (State): Thomas, W. Va.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Howard & Sunderland ADDRESS: 2303 Edmondson Ave

VS 150

46E

G81059

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81059

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Augusta T Crowley

2. DATE OF DEATH: 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3009 Guilford Ave.
c. Length of stay in Baltimore: 50 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Balto. Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3009 Guilford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | W | Widow | Jan. 14/1871 | 78 | 11 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Upper Marlboro Md. | |

13. FATHER'S NAME: John H Traband

14. MOTHER'S MAIDEN NAME: Emily C Pumphrey

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Charles E Crowley | 7108 Rich Hill Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO: Myocarditis - Senile

(B) DUE TO: Senile Arteriosclerosis

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: none

INTERVAL BETWEEN ONSET AND DEATH: 2 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Sept 1 1949 *to* Dec 19 1949, *that I last saw the deceased alive on* Dec 19, 1949, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H. Traband M. D. | 1219 Poplar Grove St. | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Loudon Park | Frederick Rd. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Acting for Thomas, M.D. | John T. Brittell & Sons, Inc. | 1300 Eutaw Place Balto. Md. |

VS 150

937

G81060 G81060

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 49-27404 Registered No. 750

1. NAME OF DECEASED (Type or Print): Baby Girl White

2. DATE OF DEATH: Dec 16. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR [illegible]: St. Joseph's (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Yrs. Mos. Days: 1 hr.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3107 McElderry St. 7-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F. | W. | Single | Dec 16. 1949 | | | | 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Newborn | | Baltimore | |

13. FATHER'S NAME: Franklin Amdrew White

14. MOTHER'S MAIDEN NAME: Eleanor Mae Morgan

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Ludenssi Morgan | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) anencephalic monster
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/16, 1949 *to* 12/16, 1949 *that I last saw the deceased alive on* 12/16, 1949 *and that death occurred at* 4.30 p.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 11 E. Chase St | 12/16/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| | 12-1-49 | Holy Redeemer | Balt Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Leonard J. Buck | 157C |

VS 150

G81061

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153

G81061

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Fannie G Lovell T

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2100 Hamilton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | W | Oct 29 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md. | USA |

13. FATHER'S NAME: Ambrose Frey

14. MOTHER'S MAIDEN NAME: Daisy Norris

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs M. J. Frey — ADDRESS: 3100 Hamilton

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebro vascular accident | 1 hr |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Obstruction pyloric ulcer to adhesions | 2 days |
| DUE TO | | |
| | (C) Abscess of site of amputation in upper thigh. | 1 mth |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 10/11/49 12/13/49 | Carcinoma sigmoid colon | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 6, 19 42 *to* Dec 20, 19 49 *that I last saw the deceased alive on* Dec 20, 19 49 *and that death occurred at* 2:15 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard Frank M.D. | Mercy Hosp | 12/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Moreland Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Leonard J Luck | 5205 Harford |

VS 150

46E

G81062

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Vol. 1 G81062 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WALTER E. ROBERTS

2. DATE OF DEATH: December 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 211 N. Fremont Avenue 4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married (Sep.) | July 12, [illegible] | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Baltimore, Maryland | |

13. FATHER'S NAME: William S Roberts

14. MOTHER'S MAIDEN NAME: Helen Payne

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Cora Roberts | 1212 Druid Hill Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arterio-Sclerotic C.V. Disease | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D | | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-22-1949 | Mt. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 939 Lombard St. |

VS 151

939

C81063

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E981

Registered No. C81063

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MORRIS SAVOY CARTER — N-8614

2. DATE OF DEATH December 16, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1501 West Franklin St. 19 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | C | Married | December 6, 1909 | 41 sml | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Washington, D. C. | U. S. A. |

13. FATHER'S NAME William Hopkins.

14. MOTHER'S MAIDEN NAME Lora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) ——

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Franklin St.
Mrs. Morris Carter, wife, 1501 W.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Gunshot injury of chest | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Sidewalk | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 300 Blk. North Parrish St. |
|---|---|---|
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-16-49 Approx. 1:25 p. m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? Firearms |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| R. S. Fraser M.D. | | 12-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-1949 | Mt. Auburn Cem. | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Mr. Katie R. Williams | 622 N. Schroeder St. |

VS 151

166

G81064

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

153

G81064 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mary T Brack (Daffin)

2. DATE OF DEATH 12/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore Yrs. 14 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 6-y Woodland Rd 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | 1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | TAILORING | Baltimore | USA |

13. FATHER'S NAME Sylvester Daffin

14. MOTHER'S MAIDEN NAME Indiana Lapsley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 219-05-0886 | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Carcinoma esophagus with generalized metastasis | 1 year |
| DUE TO (B) | Dilated pneumonia, bronchi | 5 days |
| DUE TO (C) | Alveolar pneumonia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| 12/18/49 | Carcinoma | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 1, 19 49, *to* Dec 20, 19 49, *that I last saw the deceased alive on* Dec 20, 19 49 *and that death occurred at* 5:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Rutland Frank M. D. | Mercy Hospital | 12/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | 12-23-49 | Holy Redeemer | Belair Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Chas W Faebaunhon | 703 Mc Henry St |

VS 150

46D

G81065

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 76210

G81065

BIRTH NO. 49-21557

1. NAME OF DECEASED (Type or Print): Baby Boy Michael

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2504 E. Hoffman street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 12-20-49 | | | 15 24 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | USA |

13. FATHER'S NAME: Anton Michael

14. MOTHER'S MAIDEN NAME: Eleanor Michael

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Anton Michael | 2504 E. Hoffman St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fetal Atelectasis

DUE TO

(B) Macerated Baby

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| No | No | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-20 1949 *to* 12-21 1949, *that I last saw the deceased alive on* 12-21 1949, *and that death occurred at* 12:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Whitehead M.D. | Church Home Hosp. | 12-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-21-49 | OAK Lawn | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, MD | Frank Brenk & Son | 900 N. Gilmor St. |

VS 150

161a

GB1068

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. GB1068

1. NAME OF DECEASED (Type or Print): Pearl M. Lucker

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2258 Cecil Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2258 Cecil Ave. 9-28

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | married | March 21, 1900 | 49. | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ida Cornelius
14. MOTHER'S MAIDEN NAME: Jennie S. Ars.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: John F. Lucker Sr.
ADDRESS: 2258 Cecil

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CORONARY OCCLUSION | 1 HR. |
| DUE TO | ARTERIOSCLEROSIS | 4 YRS. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | CORONARY OCCLUSION | 2 1/2 YRS. |
| DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10, 1946 *to* Dec. 21, 1949 *that I last saw the deceased alive on* Dec. 21, 1949, *and that death occurred at* 12:15 A *m., from the causes and on the date stated above.*

23A. SIGNATURE: Virginia M. Lucker, M. D.
23B. ADDRESS: 124 S. Highland Ave.
23C. DATE SIGNED: 12/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY: Moreland Mem.
24D. LOCATION (City, town, or county) (State): Taylor Ave

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mildred T. B. Light
ADDRESS: 6209 Harford Rd.

VS 150

94a

G81067

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81067

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Gross

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 234 N. Strucker st
C. Length of stay in Baltimore: 65 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-0 ✓
D. STREET ADDRESS (If rural, give location): 234 N. Strucker St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Col | Married | 1864 | 85 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Helper
10B. KIND OF BUSINESS OR INDUSTRY: Laundry
11. BIRTHPLACE (State or foreign country): Calvert Co. Md
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Leatha Dixon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Annie Gross ADDRESS: 234 N Strucker St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Cardio Vascular — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Renal Disease - Senility — 1 year

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-13-, 1949 to 12-21-, 1949 that I last saw the deceased alive on 12-19-1949, and that death occurred at 3A. m., from the causes and on the date stated above.

23A. SIGNATURE: H. L. Carlson M. D.
23B. ADDRESS: 600 N. Arlington Ave
23C. DATE SIGNED: 12/21/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/22/49 | Mt Auburn | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles A. Rice ADDRESS: 661 W. Barre St.

VS 150

121a

G81068

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Vol. 1

G81068

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Mr. Edward Kalbfleisch

2. DATE OF DEATH: Dec. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3714 Fait Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widow | 3/21/1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | OIL COMPANY | Baltimore | U.S.A. |

13. FATHER'S NAME: John Henry Kalbfleisch

14. MOTHER'S MAIDEN NAME: Theresa Greiss

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Anna Farrell - 3714 Fait Ave. ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Questionable ? Rupture of Myocardial Aneurysm. | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (B) | Myocardial Infarction (Acute Coronary Thrombosis) | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Arteriosclerosis, generalized, senile | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 12/13/ , 1949 *to* 12/19/49 , 19 , *that I last saw the deceased alive on* 12/19/ , 1949 , *and that death occurred at* 11:20AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. M. Kaan M. D. | 1400 N. Caroline Street | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Sacred Heart | German Hill Rd. Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Hunter for Williams, M.D. | Fully & Zeilach | 403 S. Wolfe St. |

VS 150

94a

G81069 Walter Dameron ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G81069

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walter Dameron

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. 7 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-07
D. STREET ADDRESS (If rural, give location): 908 N. Fulton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | M | 9/9/ | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | none | Va | U.S.A. |

13. FATHER'S NAME: Robt. Lamp Kina

14. MOTHER'S MAIDEN NAME: Laura —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Maude Williams ADDRESS 908 Fulton Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive Cardiovascular Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-14 *, 19*49*, to* 12-20 *, 19*49*, that I last saw the deceased alive on* 12-20 *, 19*49*, and that death occurred at* 12:05 *m., from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Bradley M. D. | Provident Hosp | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Warsaw | Warsaw, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Geo. H. Kelson | 1393 Broadway |

VS 150

930

G81070

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81070

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN CARTER

2. DATE OF DEATH: December 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore 50 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 149 N. High Street J-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Widow | 9-19-1870 | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | Con Bsn. | Richmond Va | U.S.A. |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): unknown

16. SOCIAL SECURITY NO.

17. INFORMANT / ADDRESS: Charles Walker 149 N. High St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| George G. Merrill M.D. | | Dec. 17, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-22-49 | Mt Calvary Cem. | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR / ADDRESS: Elroy O. Wilson 1000 Eutaw St

937

VS 151

G81071 G81071

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 442 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ida Walters (Waters)

2. DATE OF DEATH: 12/18/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1317 Madison Avenue

c. Length of stay in Baltimore: 30 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 817 N. Parrish St. 11-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widowed | 9/19/1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Canada | |

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Unkown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Ella Walters | 817 N. Parrish St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 6th, 1949, *to* December 10, 1949, *that I last saw the deceased alive on* 12-20, 1949, *and that death occurred at* 11:15 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | M. D. | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|---|
| M. L. Jackson | | 600 N. Arlington Ave | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/1949 | Mt Calvery Cem. | Balto.A.A.Co.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, MD | Elroy O. Wilson | 1000 Brantly Ave |

VS 150

131a

G81072

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

130.0

G81072

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM BANKS

2. DATE OF DEATH: Dec. 15, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 837 Leadenhall St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | col | Single | 5/10/02 | 47 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AB seaman | Seafarer | NC | USA |

13. FATHER'S NAME: William Banks

14. MOTHER'S MAIDEN NAME: Sue Banks

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | 702-03-2025 | Records- US Marine Hospital | Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) DUE TO | Pneumonia, right upper and lower lobes | 2 wks. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | Endocarditis, subacute, mural right ventricle | Unknown |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 10, 1949, *to* Dec. 15, 1949, *that I last saw the deceased alive on* Dec. 15, 1949 *and that death occurred at* 4:25 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Mt Auburn | Balto City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | J. L. Brown & Son | 109 W Montgomery St |

VS 150

108

BIRTH NO. G81073

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 9.4 G81073

1. NAME OF DECEASED (Type or Print): George O. Brown

2. DATE OF DEATH: Dec 20 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hosp.
C. Length of stay in Baltimore: Yrs. Unknown Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Balt.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1115 Arlington Ave
D. STREET ADDRESS (If rural, give location): Living Same Mental Hosp.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | 3/10/1889 | 60 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life): Machinist Metal Patternt.
10B. KIND OF BUSINESS OR INDUSTRY: Self Shop
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Thos Brown.
14. MOTHER'S MAIDEN NAME: Jane ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Cecil Brown ADDRESS: 1115 Arlington Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cystosis and pank | — |
| DUE TO (B) | Urinary Hemorrhage (Hematuria). | — |
| DUE TO (C) | Carcinoma of prostate + | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Cardiac Hypertension. | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐: 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 18, 1949 *to* Dec 20, 1949 *that I last saw the deceased alive on* Dec 20, 1949 *and that death occurred at* 6:05 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: R. O. Graham, M.D. M.D.
23B. ADDRESS: University Hosp.
23C. DATE SIGNED: 12/20/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY: London Park Cem.
24D. LOCATION (City, town, or county) (State): 3801 Frederick Ave.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son ADDRESS: 2 Eastings St.

VS 150

1336

G81074

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

96 G81074 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Quinn

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1326 James St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1326 James St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 2/27/1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Boiler Maker | B & O R R | Baltimore Md | U S A |

13. FATHER'S NAME: John Quinn

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Mamie E. Polk ADDRESS: 1326 James St.

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Sarcoma of rt femur | 6 mos |
| DUE TO (B) | none | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | none | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 8/4/49 | Sarcoma of rt femur | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 8/4 19 49 *to* 12/20 19 49 *that I last saw the deceased alive on* 12/20 19 49 *and that death occurred at* 8 P. M. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas Miller MD M. D. | 2020 W Lexington ave | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | New Cathedral | 4300 Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, MD | John J. Cowan & Son | 55E Hollins St. |

DEC 21 1949

VS 150

CERTIFICATE CORRECTED 1-5-50 Item 50 ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G81075 Registered No. G81075

1. NAME OF DECEASED (Type or Print) ROBERT J. HOLTMAN — 2. DATE OF DEATH December 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 110 S. Fremont ~~Avenue~~ Rd 2 F 04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Married | Sept. 23, 1909 | 40 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Senior Clerk | Con. Co. + Elec. Co. | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Frank Haltman | Isabelle Stuhler |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes World War #2 | 212-05-6010 | Mrs. Gladys J. Haltman |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral Hemothorax

DUE TO Multiple rib fractures

(B) Fracture, left hip

DUE TO Fracture, pelvis

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

C

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Woodington and Frederick Rds. 28/J

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) December 18, 1949 5.30 P. M.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Pedestrian struck by auto

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE W. J. McClafferty M.D. — 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ] — 23C. DATE SIGNED Dec. 19, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Baltimore National | 5201 Frederick Rd. Balto. Md |

DATE RECEIVED BY LOCAL REGISTRAR DEC 21 1949 — REGISTRAR'S SIGNATURE Huntington Williams, M.D. — 25. FUNERAL DIRECTOR Harry H. Nuttle — ADDRESS 401 Edmondson

VS 151

170C ✓ am

G81078

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

6/0

Registered No.

G81078

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William A. Stewart

2. DATE OF DEATH: Dec 18 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 830 N. Bond St.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 830 N. Bond St 7-05

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Feb. 8 1874
9. AGE (In years last birthday): 75 (If Under 1 Year: Months / Days; If Under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balt. Md.
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Elizabeth Radcliff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT: Charles N. Stewart ADDRESS: 830 N Bond

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypo Nephrosis & Uremia — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: Nov 11, 1949

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Benigned Hypertrophied Prostate — DUE TO — 1946

(C) Urinary Retention due to Prostate — Sept 1949

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Mitral Insufficiency, Generalized Arteriosclerosis

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1949 *to* Dec 18, 1949, *that I last saw the deceased alive on* Dec 17, 1949, *and that death occurred at* 10 16 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Ralph J. Young M. D.
23B. ADDRESS: 1429 E. Monument St
23C. DATE SIGNED: 12/20/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 21/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Westport Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Robt. A. Elliott & Dept
ADDRESS: 92 B 1129 N. Caroline St

VS 150

G81077

BIRTH NO. G81077

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

16 / Registered No. G81077

1. NAME OF DECEASED (Type or Print): IRVIN(MERKENS) NICKENS

2. DATE OF DEATH: 12/17/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 645 Ensor St.
c. Length of stay in Baltimore: 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 645 Ensor St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | 8/18/1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ~~Laborer~~ | Chemical Co | Whitestone, Va. | U.S.A. |

13. FATHER'S NAME: John Nickens

14. MOTHER'S MAIDEN NAME: Emmaline Fauntelroy

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | | Carrie Jones | 645 Ensor St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Larynx — DUE TO — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Same — DUE TO

(C) — —

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12 - 1 - , 1949 *to* 12 - 17 - , 1949, *that I last saw the deceased alive on* 12 - 15 - , 1949 *and that death occurred at* 11.30 *a.m. from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm H. Cargile M. D. | 611 N. Caroline St | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/21/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Lillington Williams, M.D. | Chas Harper | 512 N. Carrollton Ave |

VS 150

47a

G81078

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Reg. No. G81078

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WALTER WHITE

2. DATE OF DEATH December 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Franklin Square Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1048 Vine Street 18 0 2

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH July 16 1899
9. AGE (In years last birthday) 50 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Chemical Co
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME James White
14. MOTHER'S MAIDEN NAME Annie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO

17. INFORMANT Roseanna White — ADDRESS 1048 Vine St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Rupture of Aortic Aneurysm — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* [X], *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED Dec. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Buried
24B. DATE 12/23/49
24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem.
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 21 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Chas Harper — ADDRESS 512 Edmondson Av

VS 151

96

CERTIFICATE CORRECTED 12-27-49 Mr Elroy ✓

G81079 ~~G81079~~

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. E916-0

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WARREN MCELROY N-968

2. DATE OF DEATH December 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
St. Joseph's Hospital

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2115 Kirk Avenue 9-8

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | | Dec 30th ~~1941~~ 1940 | 8 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | - | Baltimore, Md. | |

13. FATHER'S NAME: Edward McElroy

14. MOTHER'S MAIDEN NAME: Letitia Wesser

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | - | - |

17. INFORMANT — ADDRESS: Mrs. Ed. McElroy- 1916 Christian st.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carbon monoxide poisoning | |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 2115 Kirk Avenue 9/8 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 19, 1949 3.30 a m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Conflagration-House afire |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Dec. 19, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12-21-49 | Sacred Heart of Mary | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | WIEDEFELD & SON | 180 GREENMOUNT AVE & 22ND |

VS 151

G81080

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81080
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Benjamin Latrobe Weston
2. DATE OF DEATH: Dec-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 2105 Cartendale Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Sept-8-1868 | 81 yrs | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| retired | Insurance | Balto. Md. | U.S. |

13. FATHER'S NAME: Cornelius Weston
14. MOTHER'S MAIDEN NAME: Katharine Latrobe

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | 219-05-6596 | Mrs. Virginia R. Weston (wife) | Balto. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Oedema
DUE TO
(B) Heart Disease
DUE TO
(C) Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 17, 1949, to Dec 20, 1949, that I last saw the deceased alive on Dec 20, 1949, and that death occurred at 2 P m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Chas H Pearce M. D. | 2105 N. Charles St | Dec 21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 24 49 | All Saints | Reisterstown Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR: [illegible], M.D.
25. FUNERAL DIRECTOR: Sword-Morris Co. | ADDRESS: Balto.

VS 150

95c

G81081 X G81081

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 4200

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr Thomas Vickery Wedge

2. DATE OF DEATH: 20 Dec 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4602 Lawn Park Road

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Uplands Apts.

C. Length of stay in Baltimore: Yrs. — Mos. 10 Mo — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owings Mills
D. STREET ADDRESS (If rural, give location): P. O.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widower | Nov 16 1864 | 85 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore, Md. | U. S. A. |

13. FATHER'S NAME: William T. Wedge

14. MOTHER'S MAIDEN NAME: Emily Vickery

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| None | None | None | T. V. Wedge, Jr. | 4602 Lawn Park Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Heart Disease | 6 yrs |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 1946 *to* 20 Dec 1949 *that I last saw the deceased alive on* 18 Dec 1949 *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul H. Ranck M. D. | Riderwood 8 Md. | 20 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 23/49 | Loudon Park Cems. | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | Stewart & Mowen Co., | 108 W. North Ave. |

VS 150

937

G81082

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

744.1

Registered No. G81082

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Frederick DePriest

2. DATE OF DEATH: Dec.20,1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3304 Brighton St.,

c. Length of stay in Baltimore: 6-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3304 Brighton St. 16-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Feb.25,1933 | 16 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Pa. | |

13. FATHER'S NAME: Harry J. DePriest

14. MOTHER'S MAIDEN NAME: Ruth E. Dean

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | none | Harry J.DePriest | 3304 Brighton St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Progressive Muscular Dystrophy — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Extreme Scoliosis, Heart failure

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/15, 1949, *to* 12/19, 1949, *that I last saw the deceased alive on* 12/19, 1949, *and that death occurred at* 1-- m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Brown M. D. | 1119 N Calvert St | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Lorraine Park | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | G.Howard Strong | 3207 W.North Ave., |

VS 150

156B

GS 1173 G81083

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4200 G81083

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | ANDREW MAY |
| 2. DATE OF DEATH | Dec. 19, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | Fire Dept. Infirmary Baltimore & Gay Sts., |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | |
| C. Length of stay in Baltimore | life (Yrs. Mos. Days) |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 423 N. Rose Street 6-07 |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Aug. 18, 1899 |
| 9. AGE (In years last birthday) | 50 |
| If Under 1 Year: Months, Days / If Under 24 Hours: Hours, Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Fireman |
| 10B. KIND OF BUSINESS OR INDUSTRY | Fire Department |
| 11. BIRTHPLACE (State or foreign country) | Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? | U.S. |
| 13. FATHER'S NAME | Frank May |
| 14. MOTHER'S MAIDEN NAME | Clara Kolb |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | yes Army |
| 16. SOCIAL SECURITY NO | |
| 17. INFORMANT ADDRESS | Margaret Cain May, 423 N. Rose St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — (Interval between onset and death)

DUE TO

(B) Arteriosclerotic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* December 19, 1949 *to* December 19, 1949, *that I last saw the deceased alive on* Dec. 19, 1949, *and that death occurred at* 7p.m. *m., from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
| C. O. Lloyd M. D. | Fire Dept. Gato | 12-20-49 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY |
| Burial | Dec. 23, 1949 | Sacred Heart Cemetery |
| 24D. LOCATION (City, town, or county) (State) | | |
| German Hill Rd. Baltimore, Md. | | |
| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
| DEC 21 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison St. |

VS 150

937

G81084

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81084

BIRTH NO

1. NAME OF DECEASED (Type or Print) MARIE L. ROBERS

2. DATE OF DEATH Dec. 21, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 16 Poultry St
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 1 yr (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 23-07
D. STREET ADDRESS (If rural, give location) 16 Poultry Street - Balto, Md

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months, Days, Hours, Min. | If Under 24 Hours: Min. |
|---|---|---|---|---|---|---|
| F | W | W | Sept. 25, 1870 | 78 | 9 25 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home | | Calvert County, Md | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Bowen | Mary Sinnett |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | no | Margaret Bowen | Prince Frederick |

## MEDICAL CERTIFICATION

19. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

A. Coronary thrombosis

DUE TO

B. Arteriosclerosis

DUE TO

C. Senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY occur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12/7/49 to 12/21/49 that I last saw the deceased alive on 12/20/49 and that death occurred at 2:30 A.M. from the cause and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Miller M.D. M.D. | 1224 Charles St | 12/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (If in Baltimore City, give exact location) |
|---|---|---|---|
| Burial | Dec. 24, 1949 | Broomes Island Cem. | Broomes Island, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR. ADDRESS |
|---|---|---|
| DEC 21 1949 | [redacted] | O. A. Harkins & Son - Mutual, Md |

VS 150

94a

JL- 134351 G81085 BALTIMORE CITY HEALTH DEPARTMENT G81085

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Harry McLane Tuckey

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4940 Eastern Ave. Baltimore City Hospitals

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1519 N. Collington Ave.-13

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Wid.
8. DATE OF BIRTH: Aug. 18, 1872
9. AGE (In years last birthday): 77 (If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: Railway Mail Clerk

11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ? Not Known

14. MOTHER'S MAIDEN NAME: ? Murphy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Myocardial Infarction

DUE TO

(B) Arteriosclerotic Heart Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ No ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 20, 1949 *to* Dec. 20, 1949, *that I last saw the deceased alive on* Dec. 20, 1949, *and that death occurred at* 11.30 PM *from the causes and on the date stated above.*

23A. SIGNATURE: P. S. Logan M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED: Dec. 21, 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: DEC 21 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wm. J. Tickner & Sons (ADDRESS)

VS 150

93D

G81086

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81086 Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): EMMA D. SCHULZ

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kenesaw Rest Home, 2601 Roslyn Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY: BALTO
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ CATONSVILLE
D STREET ADDRESS (If rural, give location): 1407 Frederick ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | single | Dec. 5, 1859 | 90 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - - unknown | - | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles L. Schulz | Sophie H. Schaer |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | no | Mr. Reginald D. Wilson 2601 Roslyn Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 years
DUE TO
(B) Old age
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 1, 1949 *to* Dec. 21, 1949 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard C. Blake, M.D. | Med. Arts Bldg | 12-21-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams, M.D. | M. J. BICKNER & SONS | Balto., Md. |

VS 150

92 D

G81087 ✓ G81087

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

170 Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): VIOLA R. RHODES
2. DATE OF DEATH: Dec. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1407 Lochner Rd.
C. Length of stay in Baltimore: 32 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1407 Lochner Rd. 27-C

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | married | Aug. 11, 1901 | 48 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Penna. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Rev. Elwood J. Renshaw | Anna Henry |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mr. Robert . Rhodes | 1407 Lochner Rd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Breast — Interval between onset and death: About 10 mos.
DUE TO
(B) Generalized metastases - to organs - i.e. - bone
DUE TO
(C) Transverse Myelitis due to collapse vertebrae from bone metastases

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Early 1949 | Carcinoma of Breast (right) | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from July, 1949 to 12-19-, 1949, that I last saw the deceased alive on 12-18, 1949, and that death occurred at 2:30 p. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Doman J. Hood M.D. | 2230 Garrison Blvd. Balto. 16 Md | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21st 1949 | Curington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

50

G81088

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81088

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ruth L. Page

2. DATE OF DEATH: 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 409 Hollen Road, Cedarcroft

c. Length of stay in Baltimore: 1 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 409 Hollen Road 27-12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | ------ | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | -------- | Fredericksburg, Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Robert C. Bockerman | Marion S. Woody |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Daniel S. Leonard | 409 Hollen Road |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Coronary Occlusion | 5 months |
| | DUE TO | | |
| ANTECEDENT CAUSES | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Coronary arteriosclerosis | 5 yrs. |
| | DUE TO | | |
| | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | Bronchial asthma | 15 yrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | none | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 15th 1949, to Dec. 19th 1949, *that I last saw the deceased alive on* Dec. 19, 1949, *and that death occurred at* 11 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. S. Chalfant M.D. | 6710 York Rd | Dec. 21. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/22/49 | Confederate | Fredericksburg, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Huntington Williams M.D. | H. W. Wacks & Son | 1005 N. Calvert St. |

94a

G81089

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81089

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Rose Tweddle

2. DATE OF DEATH: 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Providence Rd.

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Life / Mos. / Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | widowed | | 79 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. | Us |

13. FATHER'S NAME: Dennis Hogan

14. MOTHER'S MAIDEN NAME: Mary Craven

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs. Jackson | Same |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary Thrombosis

DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

(C) Splenic Anemia.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-15 *, 19*49 *to* 12-19 *, 19*49 *that I last saw the deceased alive on* 12-19 *, 19*49 *, and that death occurred at* 4:25 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert Hampsell M.D. | Mercy Hosp. | 12/19/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | ~~Baltimore Hebrew~~ Mrs. Mary Lee | Forest Park |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 21 1949 | Christopher Williams M.D. | H. C. Wood & Son Sons H. Calvert St | |

DS 150

94a

G81090

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

0 2 4 G81090 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALBERT DAY

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.
C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1308 Beason St. 24-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Single | 4/1/80 | 69 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Carpenter | Seafarer | New York City | USA |

13. FATHER'S NAME: William Day

14. MOTHER'S MAIDEN NAME: Martha Suter

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | ? | Records- | US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia, lobular, left lung | 1-2 weeks |
| DUE TO | Peritonitis, acute | 1-2 weeks |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | Pericholecystic abscess incised and drained 12/8/49 | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Sclerosis of lateral and posterior columns of spinal cord | Unknown |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 29, 1931, *to* Dec. 21, 1949 *that I last saw the deceased alive on* Dec. 21, 1949 *and that death occurred at* 2:45AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 12/22/49 | Green Mount | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Wm Cook Inc | 1217 St Paul St. |

VS 150

20a

G81091

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G81091

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): EMMA F. HOFMANN (HOFFMAN)

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2105 Barclay St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2105 Barclay St. 12-24

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Jan. 23, 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At. Home | Baltimore, Md. | |

13. FATHER'S NAME: Paul F. Huber

14. MOTHER'S MAIDEN NAME: Lena Fuchs

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Arthur J. Hofmann | 2105 Barclay St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive Cardio-Vascular Disease | 5 yrs. |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Uremia | 9 days |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-11, 1949, *to* 12-20, 1949, *that I last saw the deceased alive on* 12-19, 1949 *and that death occurred at* 5:20 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. D. Flynn M.D. | 11 E. Chase St. | 12-20-49 |

| 24A. BURIAL, ~~CREMATION~~, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR ~~CREMATORY~~ | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Mt Olivet | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

93D

G81092

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

307 Registered No. G81092

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles A. Roeder

2. DATE OF DEATH: Dec. 19 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):
c. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1521 Linden Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Oct. 4, 1884 | 65 | 2 15 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Electrician | | Baltimore Md. | |

13. FATHER'S NAME: John Roeder

14. MOTHER'S MAIDEN NAME: Emily Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Emily Murphy ADDRESS: 4503 Fullerton Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | |
| DUE TO (B) | acute hepatitis + retention of urea | 6 days |
| DUE TO (C) | Delirium Tremens - alcoholism | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 13, 1949, *to* Dec 19, 1949, *that I last saw the deceased alive on* Dec. 19, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles S Nevitt M. D. | 1730 Linden Ave | Dec 21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-22-49 | Baltimore | North Ave + Rose st. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, MD | Wm. Cook Inc. | 1211 St. Paul St. |

VS 150

77D

G81093

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81093

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Flora Hayden

2. DATE OF DEATH: 12/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Belair
D. STREET ADDRESS (If rural, give location): 315 E. Broadway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | July 25, 1874 | 75 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hwf.

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Napoleon Grimes

14. MOTHER'S MAIDEN NAME: Amy F. Walker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis & Myocardial Dysentria

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive-Arteriosclerotic Cardio Vascular Renal

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/15, 1949, *to* 12/22, 1949 *that I last saw the deceased alive on* 12/22, 1949, *and that death occurred at* 3:10 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: John V. Pompella M. D.

23B. ADDRESS: Mercy Hospital

23C. DATE SIGNED: 12/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec 24/49

24C. NAME OF CEMETERY OR CREMATORY: Mt Zion

24D. LOCATION (City, town, or county) (State): Belair Harford Co Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Joseph T. Foster ADDRESS: Belair Md

VS 150

93D

G81094

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 6 / 0

Registered No. G81094

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM SHIPLEY

2. DATE OF DEATH: DEC. 19, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland UNIVERSITY HOSP
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL
c. Length of stay in Baltimore: 76 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2124 RAMSEY ST. 20-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RAILROAD EMPLOYEE | | MD. | U.S.A. |

13. FATHER'S NAME: WILLIAM SHIPLEY

14. MOTHER'S MAIDEN NAME: ISABELLE GREEN

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | WILLIAM SHIPLEY — SON |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) HEMORRHAG FROM URINARY TRACT.

DUE TO

(B) BENIGN PROSTATIC HYPERTROPHY.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| DEC. 18, 1949 | HEMORRHAG AN VESICLE NECK | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 16, 1949 *to* Dec 19, 1949 *that I last saw the deceased alive on* Dec 19, 1949, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edmund B. Middleton M.D. | University Hospital | Dec 17, 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12/22/49 | SMITH'S FAMILY CEMETERY | CAMP MEADE ROAD, A.A.Co. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 22 1949 | Huntington Williams M.D. | JOHN F. DENNY, INC. 715 LIGHT ST. |

VS 150

1370

G81095 PIEREMAN ✓

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

153 Registered No. G81095

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GLADYS F. PIEREMAN

2. DATE OF DEATH: 20 Dec 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Good Samaritan Hosp 27 N. Carey St (23)
C. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md —
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 23 — 07
D. STREET ADDRESS (If rural, give location): 1057 S. Charles St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | June 27 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife — | at Home | Baltimore, Md | U.S.A. |

13. FATHER'S NAME: (?) Burdette

14. MOTHER'S MAIDEN NAME: ? ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Katherine E Wagner (Daughter) ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH 1320 S. Howard St.

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of the Sigmoid
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Aug 1949 | Colostomy for carcinoma of sigmoid | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 15 Sept, 1949 *to* 20 Dec, 1949, *that I last saw the deceased alive on* 20 Dec, 1949, *and that death occurred at* 1 45 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil H. Henning M. D. | 601 Winans Way | 21 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 23, 1949 | Cedar Hill Cem. | Q. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | J. Howard Evans | 1400 S. Charles St Balto 30, Md. 46E |

VS 150

G81096

G81096

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lolue Bennett

2. DATE OF DEATH: Dec. 19, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Col 2 ward

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 57 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 102 N. Dallas St

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 10-13-1895
9. AGE (In years last birthday) — If under 1 year: Months / Days; If under 24 hours: Hours / Min.:
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ernest Bennett
14. MOTHER'S MAIDEN NAME: Elvira Lacuna
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis, Bilateral — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Far Advanced

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-25-, 1949, to 12-19-, 1949, *that I last saw the deceased alive on* 12-19-, 1949, *and that death occurred at* 1:43 a m., *from the causes and on the date stated above.*

23A. SIGNATURE: Reed Dukens M. D.
23B. ADDRESS: JOHNS HOPKINS HOSP
23C. DATE SIGNED: 12-20-49 (Date)

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/22/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county): Brooklyn Md ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949
REGISTRAR'S SIGNATURE: Tuntington Williams
25. FUNERAL DIRECTOR: Elroy B. Wilson 1545 Bradley ave

VS 150

13B

G81097

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331

Registered No. G81097

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNIE E. BRENDEL

2. DATE OF DEATH: I2/I9/49

3. PLACE OF DEATH: A. Baltimore City, Maryland I235 Battery Avenue

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): I235 Battery Avenue 24 03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | W | 7/I0/I866 | 83 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles Buckman | Emaline Molloy |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Family | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 1 wk

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis — 3 yr.+

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949, to Dec. 19, 1949, *that I last saw the deceased alive on* Dec. 19, 1949 *and that death occurred at* 4 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. McCollod, M. D. | 707 Fort Ave. | 12-20-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | I2/22/49 | Loudon Park | 3801 Frederick Avenue |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | James L. McCaney | 130 E. Fort Ave. |

VS 150

83a

G81098

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

330

G81098

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Alfred Harris

2. DATE OF DEATH: 12-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 3 Weeks (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2320 Ettings St

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Single | Aug. 13, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| unemployed | | Mary Etta Pa. | U.S.A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| | | | Charles Harris - 126 Edgecombe ave. New York |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Accident (Subarachnoid Hemorrhage)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(INTERVAL BETWEEN ONSET AND DEATH)

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-16-49 19 , *to* 12-19-, 19 49, *that I last saw the deceased alive on* 12-19-19 49, *and that death occurred at* 11:30 *m., from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | | Lancaster Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | A. Halstead | 915 Druid Hill Ave. |

VS 150

83a

G81099

# CERTIFICATE CORRECTED 1-9-50

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

754.6

G81099

BIRTH NO. —

Registered No.

1. NAME OF DECEASED (Type or Print): Henry John Stricker

2. DATE OF DEATH: December 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1417 Hanover Street 2 3 0 1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | White | MARRIED | Oct. 27, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chef - Cook | Hochshild Kohn Co. | BALTIMORE, MARYLAND | U.S. |

13. FATHER'S NAME: Antone Stricker

14. MOTHER'S MAIDEN NAME: Margaret Koerner

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 216-03-4892 | Theresa M. Stricker | 1411 Hanover Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs + 10 min
DUE TO
(B) Congenital Cerebral Aneurysm
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Nov. 25, 1949, *to* Dec. 20, 1949, *that I last saw the deceased alive on* Dec. 20, 1949, *and that death occurred at* 9:40 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. A. Roberts M. D. | Mercy Hospital | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC-24-49 | HOLY CROSS CEM. | A A Co MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Bernard C. Haus | 121 E. West St |

VS 150

1579

G81100

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903.0 G81100

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mrs. Elizabeth Mary Meckel

N-8210

2. DATE OF DEATH: December 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Maryland; B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 1526 Riverside Avenue

24-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Fe. | White | Widowed | March 19, 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Wife. | At Home | Baltimore, Maryland | U.S. |

13. FATHER'S NAME: Adam Huemmer

14. MOTHER'S MAIDEN NAME: Dorothy Kaufman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Charles Meckel | 1526 Riverside |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Fractured hip - left

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Hypertensive + arteriosclerotic cardiovascular disease

CERTIFICATION APPROVED BY

Per John R. Davis

R B Fisher M.D.

CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | 1526 Riverside Ave. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Sept. 7, 1949 6 P m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Missed chair & fell to floor |

22. *I hereby certify that I attended the deceased from* 11/1/ , 1949, *to* 12/22/ , 1949, *that I last saw the deceased alive on* 12/22/ , 1949, *and that death occurred at* 2:52AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Andrew Cearns M. D. | 1400 N. Caroline Street | 12/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC 26-49 | Holy Cross | A. A. Co. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Bernard C. Hank | 121 E. North St |

186a

G81101

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 171

Registered No. G81101

BIRTH NO.

1. NAME OF DECEASED (Type or Print): RAY M. HENDERSON

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2623 W. Cold Spring Ave.
C. Length of stay in Baltimore: 8 Yrs. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2623 W. Cold Spring Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | January 8, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Domestic | Allentown, Penna. | U. S. |

13. FATHER'S NAME: George Thill

14. MOTHER'S MAIDEN NAME: Annie ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | None | Samuel H. Henderson | 2623 W. Cold Spring Ave. Baltimore, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cascinoma of cervix uteri | 2 1/2 yrs. |
| DUE TO (B) | Metastases to lungs and mediastinal lymph glands. | 2 1/2 yrs. |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT SUICIDE HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/26, 1949 to 12/20, 1949 that I last saw the deceased alive on 12/19, 1949, and that death occurred at 7 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Robert A. Reitz, M. D.

23B. ADDRESS: 3408 W Indsor Ave

23C. DATE SIGNED: 12/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/23/49.

24C. NAME OF CEMETERY OR CREMATORY: London Park Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949

REGISTRAR'S SIGNATURE: Curtis Worthington Williams, M.D.

25. FUNERAL DIRECTOR: Easton Sons

ADDRESS: Ellicott City, Md.

VS 150

48a

G81102 × ✓ 170 G81102

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY TITTSWORTH

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ 28 Lutherville
D. STREET ADDRESS (If rural, give location): 201 Westshire Road

| 5 SEX | 6 COLOR or RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | W | M | 5-19-1911 | 38 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Maryland | |

| 13. FATHER'S NAME | 14 MOTHER'S MAIDEN NAME |
|---|---|
| George Myers | Sadie Aikman |

| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO. | 17 INFORMANT ADDRESS |
|---|---|---|
| No | ? | Claude Tittsworth, Catonsville, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Generalized Carcinomatosis | |
| DUE TO (B) | Carcinoma of Breast | |
| DUE TO (C) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pathological Fracture, left femur | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-8- , 1949, to 12-21- , 1949, *that I last saw the deceased alive on* 12-21- , 1949, *and that death occurred at* 3:00 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | University Hospital | 12-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-24-49 | St. Johns | Ellicott City, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 22 1949 | [signature] | F.C. Higinbotham, Ellicott City, Md. |

VS 150

50

G81103

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G81103

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SADIE SIMPSON

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1838 N. Caroline St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1838 N. Caroline St.
c. Length of stay in Baltimore: Yrs. 8 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1729 N. Caroline St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Nov. 23, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | | Baltimore Md | |

13. FATHER'S NAME: Jesse K. Hall

14. MOTHER'S MAIDEN NAME: Ann Keelan

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. M. Warwick | 1838 N. Caroline St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 weeks
DUE TO
(B) Essential hypertension 5 yrs.
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Malignancy of colon?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct. 14 1949 *to* Dec. 20 1949 *that I last saw the deceased alive on* Dec. 20 1949 *and that death occurred at* 7 ?.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. H. Krenzer, M.D. | 1428 Mosher Rd. | 12.21.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Baltimore | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | M. Fahey & Sons | 1827 W. North Ave. |

VS 150

83a

G81104

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81104

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Annie Jones 1676 Eagle St

2. DATE OF DEATH Dec 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1674 E. Eagle St

c. Length of stay in Baltimore 34 yrs. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md B. COUNTY Balto
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 1674 Eagle St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years — last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Feb 24 1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY Housewife

11. BIRTHPLACE (State or foreign country) South Wales

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James G. Jones

14. MOTHER'S MAIDEN NAME Ann Emeline Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Ann Bigham ADDRESS 1674 Eagle St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.
DUE TO
(B) Myocardial degeneration, Arteriosclerosis
DUE TO
(C) Arteriosclerosis, several years.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ____, 1947 to 12/20, 1949 that I last saw the deceased alive on 12/20, 1949 and that death occurred at 11:35 a.m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D. | 23B. ADDRESS 332 S Frederick St | 23C. DATE SIGNED 12/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Memorial | 24D. LOCATION (City, town, or county) (State) Hanover - Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 22 1949 | REGISTRAR'S SIGNATURE [signature] for Millemus, M.D. | 25. FUNERAL DIRECTOR Geo. A. Hughes ADDRESS Reisterstown Md

VS 150

93D

G81105

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 174

G81105

1. NAME OF DECEASED (Type or Print): ANNA M. RICE

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2139 E. Oliver St.

C. Length of stay in Baltimore: Yrs. 5 Mos. 4 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2139 E. Oliver St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| female | white | married | July 14, 1900 | 49 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | Baltimore, Md. | |

13. FATHER'S NAME: John Rohlfing

14. MOTHER'S MAIDEN NAME: Anna G. Kraft

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| -- | -- | Mr. Joseph H. Rice | 2139 E. Oliver St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Uterus

DUE TO

(B) Metastasis to adrenal Bladder - Colon + Chest.

DUE TO

(C) Recto-Vaginal Fistula Intestinal Obstruction & Metastasis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| July - 1949 | Carcinomatous areas of tissue Pelvis | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 17 '49 *to* Dec 21 '49, *that I last saw the deceased alive on* Dec 20 1949 *and that death occurred at* 12:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter A. Anderson M.D. | 300 Shannon Drive (13) | Dec 21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Balto. Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

48 B

G81106 **CERTIFICATE CORRECTED** 1-11-1950 ✓

David Lee Staley Sr.

**BALTIMORE CITY HEALTH DEPARTMENT**

**CERTIFICATE OF DEATH** 193

G81106

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Staley, David Lee Sr.

2. DATE OF DEATH 12-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore Yrs. 5 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY WASHINGTON
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerstown
D. STREET ADDRESS (If rural, give location) 729 Sunnit Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| M | W | ~~MARRIED~~ WIDOWED | Jan. 3, 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Manager of State Unemployment Office | | Breathedsville, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Daniel Howard Staley | Margaret Boothe |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ---- | None | Mrs. Hazel K. Staley | |

MEDICAL CERTIFICATION

19. CAUSE OF DEATH

I
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Glioma, brain, right parietal — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS**, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST.

(B)

DUE TO

(C)

II
**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-20-49 | Glioma right parietal lobe, brain | YES ☒ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-17, 1949 *to* 12-22, 1949, *that I last saw the deceased alive on* 12-22, 1949, *and that death occurred at* 12:40 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James Shuford M. D. | Univ. Hosp. | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Episcopal Cem. St Matthew's | Wash. Co. Funkstown Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Tunstington Williams, M.D. | E. R. Hoffman | Hagerstown, Md. |

VS 150

54a Hagerstown Md

G81107

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81107

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERT BELL

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1540 N. Bruce St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1540 N. Bruce St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Col | M | Jan. 1 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanic | Auto repair | Baltimore, Md. | U. S. A. |

13. FATHER'S NAME: Emanuel Bell

14. MOTHER'S MAIDEN NAME: Clara ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-10-0874

17. INFORMANT: Carrie Bell ADDRESS: 1540 N. Bruce St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Mitral insufficiency — INTERVAL BETWEEN ONSET AND DEATH: one year

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-5- 1949 *to* 12-20- 1949 *that I last saw the deceased alive on* 12-20- 1949 *and that death occurred at* 15 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George C. Page M. D. | 816 N. Mount St. (17) | 12-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Mt Auburn | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Geo. H. Nelson | 1363 Pennsylvania Ave. |

VS 150

92 R

G81108

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81108 Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): Kline, Claudine Marie

2. DATE OF DEATH: Dec. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-10
D. STREET ADDRESS (If rural, give location): 546 Beaumont Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. for Women of Maryland

c. Length of stay in Baltimore: 28 yrs (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Divorced | March 1, 1921 | 28 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife or none | — | Washington D.C. | US |

13. FATHER'S NAME: Kline, Edward

14. MOTHER'S MAIDEN NAME: Bozman, Estel

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 213-10-7759 | Pt. herself | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of cervix — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | — |

22. *I hereby certify that I attended the deceased from* Dec. 15, 1949 *to* Dec. 22, 1949 *that I last saw the deceased alive on* Dec. 22, 1949, *and that death occurred at* 8:20 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edw. T. Bennett M.D. | Women's Hospital | Dec 22, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Ft. Lincoln Cem. | Washington D.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Chas. H. Evans & Son Inc | 118 W. Mt. Royal Ave 48a |

G81109

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81109 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Webster Hamby

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 5506 Norwood Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. 8 years Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 5506 Norwood Ave. 28-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 10-3-1864 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | | Maryland | |

13. FATHER'S NAME: James Webster Hamby

14. MOTHER'S MAIDEN NAME: Louisa Bunce

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT: Martha Amelia Hamby ADDRESS: 5506 Norwood

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C) Senility

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING (I): Chronic Nephritis — 5 yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| No Operation | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 6, 1944 *to* Dec 21, 1949, *that I last saw the deceased alive on* Dec 20, 1949, *and that death occurred at* 11 30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joshua H. Armacost M.D. | 6719 Windsor Mill Rd | Dec 22, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Calvary Cemetery | Calvary Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Washington Williams, M.D. | Ellsworth Armacost | 1310 5118 Gwynn Oak Ave. |

VS-150

G81110

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81110

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ida Zeuler

2. DATE OF DEATH Dec. 20-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 524 N Reynolds Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

D. STREET ADDRESS (If rural, give location) 524 N. Reynolds Ave 1-03

c. Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 6-21-1873 | 76 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Germany | |

13. FATHER'S NAME Ferdinand Rosowski

14. MOTHER'S MAIDEN NAME Louise Meisner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Curtis-Sis | 524 Reynolds Ave |

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — (INTERVAL BETWEEN ONSET AND DEATH)

DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.**

(B) Arterio sclerosis

DUE TO

(C) Diabetes Mellitus — 3 yrs.

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 1946 *to* Dec 20- 1949 *that I last saw the deceased alive on* Dec 20 1949 *and that death occurred at* 9 A. *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Eugene Zeller M. D. | 2739 Eastern Ave | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Moreland Mem. Park | Taylor Ave. Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Huntington Williams, MD | John C. Miller Inc. | 2035 E. Oliver St |

VS 150

61

G81111

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

33

G81111
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Margaret Ruppel

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2123 E. Oliver St.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 8-04
D. STREET ADDRESS (If rural, give location): 2123 East Oliver St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | May 8-1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Ott
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Amalia Klasing ADDRESS: 2123 E. Oliver St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Terminal Pneumonia | 9 days |
| DUE TO | Hypostatic congestion | " " |
| (B) | Paraplegia | |
| DUE TO | Cerebral hemorrhage<br>Arteriosclerosis | 2 yrs. |
| (C) | | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 1949 *to* Dec. 21, 1949 *that I last saw the deceased alive on* Dec. 20, 1949, *and that death occurred at* 3 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Alfred J. Fitzgerald M. D.
23B. ADDRESS: 1613 E. North Ave.
23C. DATE SIGNED: 12-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-23-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: John C. Mather Inc. ADDRESS: 2435 E. Oliver St

VS 150

832a

G81112

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G81112 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Howard Eldridge
2. DATE OF DEATH: December 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 4
D. STREET ADDRESS (If rural, give location): 11 H Emmanuel Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | March 15, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chauffer | M. S. Kirsch | Baltimore, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Eldridge | Emma Washburn |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| yes U.S.Army | | JOHNS HOPKINS HOSP. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage

DUE TO

(B) Hypertensive Cardio Vascular disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-21, 1949 *to* 12-21, 1949, *that I last saw the deceased alive on* 12-21, 1949, *and that death occurred at* 9:54 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edythe H. Schraemli M.D. | JOHNS HOPKINS HOSP. | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Baltimore Nat. Cem. | Frederick Rd., Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 22 1949 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 150

93D

G81113 BALTIMORE CITY HEALTH DEPARTMENT Reg. No. 1 G81113

# CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED (Type or Print): EDWARD LEE McKENNA

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 812 Hollins St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 812 Hollins St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Sept. 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | Self and others | Baltimore, Md. | |

13. FATHER'S NAME: William J. McKenna

14. MOTHER'S MAIDEN NAME: Mary T. Allenbuth

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W. 1 | | Renate K. McKenna | 2515 Lauretta Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 3 mo |
| DUE TO (B) | Arterio Sclerosis | 3 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 12-1- 1949 *to* 12-20- 1949, *that I last saw the deceased alive on* 12-19- 1949, *and that death occurred at* 5.30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Hubert C. Blake M.D. | Med. Arts Bldg | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | National | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Easton Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

94a

G81114 BALTIMORE CITY HEALTH DEPARTMENT G81114

# CERTIFICATE OF DEATH

BIRTH NO. 33 0 Registered No.

1. NAME OF DECEASED (Type or Print): Jeff Pickett
2. DATE OF DEATH: 12-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 840 Georgia Ave. 17-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years if over 1 birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M. | Col. | Married | May 4 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | S. C. | |

13. FATHER'S NAME: Jeff Pickett
14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or Unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Joseph Pickett | 840 Georgia St |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage — Interval between onset and death: 2 days
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12-18-49, 19__, *to* 12-19-49, 19__, *that I last saw the deceased alive on* 12-19-49, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | Provident Hosp | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Dec 22/49 | | Scotland S. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Kenneth Williams, M.D. | Mrs Ethel G. Elliott & Daughter | 1297 N. Carlton St |

VS-10

836

G81115 ✓ G81115

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. 151 Registered No. 3694

1. NAME OF DECEASED (Type or Print): Eulalia M. Collins

2. DATE OF DEATH: 12/20/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1129 N. Carey St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1129 N. Carey St. - 16

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 5, 1895
9. AGE (In years last birthday): 54
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James Walker
14. MOTHER'S MAIDEN NAME: Amanda J. Walker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Richard Collins ADDRESS: 1129 N Carey St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Gastric Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 18 months
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Unknown
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1-1948 *to* 12-20-1949 *that I last saw the deceased alive on* 12-19-1949 *and that death occurred at* 5:30A m., *from the causes and on the date stated above.*

23A. SIGNATURE: James Saunders M. D.
23B. ADDRESS: 1029 N. Stricker St.
23C. DATE SIGNED: 12-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 24/49
24C. NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery
24D. LOCATION (City, town, or county) (State): Balto Md
DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Mrs. Robert A. Elliott & Daughter
ADDRESS: 460 1129 N. Carolina St

G81116 133974

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

18 Registered No. G81116

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Santiago, Porta.

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1624 E. Oliver St. Z 19

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 1, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Engineer | ? | Spain. | U.S.A. |

13. FATHER'S NAME: Camelo, Porta.

14. MOTHER'S MAIDEN NAME: Beatrice

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | ? | Records B.C.H. | 4940 Eastern Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Generalized metastatic carcinomatosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Squamous cell carcinoma of the bladder | |
| DUE TO | | |
| | (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cirrhosis of the liver | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-16-49 | Diagnosis of Cancer | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12-5- , 1949, *to* 12-21- , 1949, *that I last saw the deceased alive on* 12-21- , 1949, *and that death occurred at* 7.30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 4940 Eastern Ave. | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12/26/49 | BALTO. CEM. | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | [signature] | MILLY & ZEILER INC. | BALTO. MD. |

VS 150

526

G81117

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81117

Registered No.

1. NAME OF DECEASED (Type or Print): CARRIE BRENNER

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 511 S. Chapel St.
c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 511 S. Chapel St. 2-03

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1/27/1885
AGE (In years last birthday): 64
If under 1 year: Months, Days
If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John T. Tracy
14. MOTHER'S MAIDEN NAME: Mary Ann Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: ?
17. INFORMANT: Fred Brenner
ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis
DUE TO Angina Pectoris, Coronary Sclerosis
(B) Diabetes Mellitus, Chronic Rheumatism & Arthritis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH
(A) acute
(B) ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1949, to Dec 21, 1949, *that I last saw the deceased alive on* Dec 20 1949 *and that death occurred at* 4:34 m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 7007 E. Pratt St.
23C. DATE SIGNED: 12-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/24/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, Town, or County) (State): Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zeiler Inc.
ADDRESS: Balto.

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G81118

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

177 Registered No. G81118

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH FRANCIS HESS

2. DATE OF DEATH: 12/19/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 920 S. CLINTON ST.

C. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 26-11
D. STREET ADDRESS (If rural, give location): 920 S. CLINTON ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | WIDOWED | 4/11/1867 | 82 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): POLICEMAN
10B. KIND OF BUSINESS OR INDUSTRY: CITY
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: FERDINAND HESS
14. MOTHER'S MAIDEN NAME: CATHERINE ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: ?
17. INFORMANT: FERDINAND HESS ADDRESS: 202 N. CONKLING ST.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Prostate c

DUE TO

(B) metastasis to neck

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: Oct 19/48

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: as above
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): None
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): None
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): None
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from Nov 10, 1949, to Dec 19, 1949, that I last saw the deceased alive on Dec 18, 1949 and that death occurred at 7 00 P m., from the causes and on the date stated above.

23A. SIGNATURE: E. Schimunek M. D.
23B. ADDRESS: 942 S. Eutaw
23C. DATE SIGNED: 12-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER
24D. LOCATION (City, town, or county) (State): BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D.
25. FUNERAL DIRECTOR: WILLEY & LEILER, INC.
ADDRESS: BALTO.

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G81119

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81119

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Virginia R. Miller

2. DATE OF DEATH: Dec. 20th 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Hilton St. Nursing Home Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Allenton Nursing Home Hilton St. Balto Md

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. COUNTY: Baltimore (?) Md
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 11-02
D. STREET ADDRESS (If rural, give location): 28 E. Mt Vernon Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | ? | about 87 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none. | | W. Va. | U.S.A. |

13. FATHER'S NAME: Oliver Ruckle

14. MOTHER'S MAIDEN NAME: Margaret Rogers.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs Elizabeth Schultz ADDRESS 1848 Eastern Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 3 week |
| DUE TO (B) | Myocardial Insufficiency | 1 year |
| DUE TO (C) | uterine - Hernia | un |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | te | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| — | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | | — |

22. *I hereby certify that I attended the deceased from* Dec. 20th, 1949, *to* Dec. 20th, 1949, *that I last saw the deceased alive on* Dec 20th, 1949, *and that death occurred at* 1:15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| L.A. Chatard M.D. | 1300 N. Aliceanna St. | Dec 22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 23/49 | Druid Ridge | Pikesville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 22 1949 | Huntington Williams M.D. | Young Byers & Son | Pikesville Md. |

VS 150

937

G81120

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

33 ✓ G81120 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARAH KUDER
2. DATE OF DEATH: 12-22-49
3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto.Md.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levendale Home, City.
c. Length of stay in Baltimore: 40yrs. (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY: Balto.Md.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2242 Brookfield Ave. Greenspring Ave. Belvedere &
D. STREET ADDRESS (If rural, give location): 2242 Brokfield Ave. 13-27
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow.
8. DATE OF BIRTH: Sept. 7th. 1967.
9. AGE (In years last birthday): 82 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.): 3 15
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Ohio.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Epstine,
14. MOTHER'S MAIDEN NAME: Rebecca Heinaman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Miss Kuder — ADDRESS: 2242 Brookfield Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral thrombosis | 4 days |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis | years |
| DUE TO | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | Myelogenous Leucemia | ? |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-27-49 *to* 12-22-49, *that I last saw the deceased alive on* 12-22-49, *and that death occurred at* 5 p. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Nagel M. D.
23B. ADDRESS: Levendale Home
23C. DATE SIGNED: 12-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 23rd. 1949
24C. NAME OF CEMETERY OR CREMATORY: Balto. Hebrew Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Thurlington Williams, M.D.
25. FUNERAL DIRECTOR: Rec Funeral Chapel Inc
ADDRESS: 1902 Eutaw Place

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DEC 22 1949

74a

G81121

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO.

Registered No. G81121

1. NAME OF DECEASED (Type or Print): FRANK J. MEYD

2. DATE OF DEATH: DEC. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2520 W. Fairmount St.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2520 W. Fairmount Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | Married | Nov. 17, 1881 | 68 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George C. Meyd
14. MOTHER'S MAIDEN NAME: Annie Mueller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Eliz. Meyd
ADDRESS: 2520 W. Fairmount Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Thrombosis Coronary
DUE TO
(C) Hypertension & Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH
(A) 3 hr.
(B) 15 yr.
(C) 10 yr - 24 yr.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 5, 1949 *to* Dec 20, 1949 *that I last saw the deceased alive on* Dec 20, 1949 *and that death occurred at* m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 1933 W. Baltimore St
23C. DATE SIGNED: 12/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Cross
24D. LOCATION (City, town, or county) (State): Anne Arundel Co.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 22 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR: George A. Fahey
ADDRESS: Fulton Ave. & Fayette St.

VS 150

130

G81122

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

46 4

Registered No. G81122

1. NAME OF DECEASED (Type or Print): Helen May Pullman

2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 411 Millington Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21
D. STREET ADDRESS (If rural, give location): 411 Millington Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | July 30, 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Finisher | Brush Handles | Maryland | U.S.A |

13. FATHER'S NAME: Charles E. Davis

14. MOTHER'S MAIDEN NAME: Emma E Garritee

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No. None | 212-07-3850 | Eugenia M. Meyett | 411 Millington Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary embolus | 1 day |
| DUE TO (B) | Thrombophlebitis | 3 mons |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | None | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 1, 1949, *to* Dec 20, 1949, *that I last saw the deceased alive on* Dec 20, 1949, *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Benjamin Miller M.D. | 1030 W Belvedere Ave. | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | / | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | George L. Schwab | 2101 Frederick Ave. |

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G8L123

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 9 10.1

Registered No. G8L123

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Noah May — N-809-2

2. DATE OF DEATH: 12/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — St. Agnes Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sykesville
D. STREET ADDRESS (If rural, give location): Radcliff Farm, Sykesville

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 17, 1898
9. AGE (In years last birthday): 50 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Log Piling
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Landus May
14. MOTHER'S MAIDEN NAME: Mary Parsons
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Jacob C. May — ADDRESS: Sykesville Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive cardiovascular renal disease
DUE TO
with Pulmonary Edema, Hydrothorax + Ascites.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

CERTIFICATION APPROVED BY
Dr. William Helfrich per
B B Fisher M.D.
(SIGNATURE OF ATTENDING PHYSICIAN OR CORONER)

Fracture pelvis, ischium, sup. femur + st. trivial + cachexia? Anemia

INTERVAL BETWEEN ONSET AND DEATH: ?

19A. DATE OF OPERATION: 5/27/49
19B. MAJOR FINDINGS OF OPERATION: Comminuted Fracture Femur RIGHT
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): Accident
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): farm.
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Radcliff Farm Sykesville
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 4 16 49 m.
21E. INJURY OCCURRED: WHILE AT WORK X — NOT WHILE AT WORK
21F. HOW DID INJURY OCCUR? Log rolled over body.

22. I hereby certify that I attended the deceased from 4/16, 1949 to 12/22, 1949 that I last saw the deceased alive on 12/22, 1949 and that death occurred at 2:45 P m., from the causes and on the date stated above.

23A. SIGNATURE: B B Ramsay M.D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 12/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/23/49
24C. NAME OF CEMETERY OR CREMATORY:
24D. LOCATION (City or County) (State): Abingdon, Va

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Wilson Cook
ADDRESS: 1217 Druid Park Dr

VS 150

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195E

G81124

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81124

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Carrie T. Faulkner

2. DATE OF DEATH: 12/2/49 9:40 a.m.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5619 Gorsuch Ave
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 22 - 7
D. STREET ADDRESS (If rural, give location): 5619 Gorsuch Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 6/20/1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Practical Nurse | Private Duty | Balto. Md. | |

13. FATHER'S NAME: John Luskin

14. MOTHER'S MAIDEN NAME: Currie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Grace Yount ADDRESS: 5619 Gorsuch Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertension Cardiovascular disease | 2 yrs. |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 1933 19- *to* Dec 1 1949 *that I last saw the deceased alive on* Dec 1 1949 *and that death occurred at* 9 4:50 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. E. Chalfant M. D. | 610 York Rd | Dec 2. 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/23/49 | Parkwood | Parkville Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949

REGISTRAR'S SIGNATURE: Hamilton Williams, M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St. Paul St

VS 150

937

G81125

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

57

G81125

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Ella McKay Linsley

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Unknown Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 3711 Greenmount Avenue 9-01

5. SEX: Female
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 23, 1884
9. AGE (In years last birthday): 65
If Under 1 Year: Months | Days
If Under 24 Hours: Hours | Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Connecticut
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James G. McKay
14. MOTHER'S MAIDEN NAME: Julia Hoyt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Patient
ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of pancreas
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: ? 6 mos.

19A. DATE OF OPERATION: Aug 1949
19B. MAJOR FINDINGS OF OPERATION: Carcinoma of pancreas
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-12-49, 19 *to* 12-21, 1949, *that I last saw the deceased alive on* 12-21, 1949, *and that death occurred at* 1 50 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: Frank Snyder III, M. D.
23B ADDRESS: Union Memorial Hosp.
23C DATE SIGNED: 12-21-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: 12/24/49
24C NAME OF CEMETERY OR CREMATORY: Mt. Olivet
24D LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25 FUNERAL DIRECTOR: Wm Cook Inc.
ADDRESS: 1217 St. Paul St.

VS 150

469

G81126

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81126

1. NAME OF DECEASED (Type or Print): EMMA L. McCAULEY

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 803 W. North Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 803 W. North Ave. 13-C Y

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Apr. 7, 1855 | 94 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland, U.S. | |

13. FATHER'S NAME: John Wilhelm

14. MOTHER'S MAIDEN NAME: Sarah E. Wilhelm

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs Henry E. Bollinger | 301 E. 33 St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uraemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cardio-vascular renal disease — 3 y 8 m.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* December, 1948, *to* Dec 21, 1949 *that I last saw the deceased alive on* Dec. 21, 1949, *and that death occurred at* 8:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lloyd E. Taylor M. D. | 3902 Greenmount Ave. | Dec. 22 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Woodlawn | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Cuntington Williams, M.D. | Wm Cook Inc. | 127 St. Paul St. |

VS 150

131a

BIRTH NO. G81127

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81127

1. NAME OF DECEASED (Type or Print): Alice Lohr

2. DATE OF DEATH: 12/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 923 Lennox St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 923 Lennox St 13-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | 1/5/1875 | 74 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | Self | Va. | |

13. FATHER'S NAME: Wm Walters

14. MOTHER'S MAIDEN NAME: Mahala Hoffman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mattie V. Murphy | 414 Gorsuch Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) Arteriosclerotic C. V disease
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| C. L. Schneider M.D. | | 12/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/26/49 | Druid Ridge | Pikesville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Wm Cook Inc | 1217 St. Paul St. |

VS 151

937

G81128

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4 no. 1

Registered No. G81128

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Samuel Siegel

2. DATE OF DEATH: Dec 22 | 49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1527 N. Smallwood St.

C. Length of stay in Baltimore: 21 YRS. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Mayland COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15 03
D. STREET ADDRESS (If rural, give location): 1527 N. Smallwood St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 17, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | | Russia | |

13. FATHER'S NAME: Robert Siegel

14. MOTHER'S MAIDEN NAME: Fannie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Jennie Siegel ADDRESS 1527 N. Smallwood St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

(B) Coronary Sclerosis — 3 years

DUE TO

(C) Arteriosclerosis — ?

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 1947 *to* Dec. 22, 1949 *that I last saw the deceased alive on* Dec. 22, 1949 *and that death occurred at* 7 AM/PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert Goldstone M. D. | 1810 Eutaw Pl. | Dec. 23, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Hebrew Rosedale | Balto - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, MD | Sol. Levinson & Bro | 1124-26 North Ave |

VS 150

94a

G81129

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

450.0

Registered No. G81129

BIRTH NO.

1. NAME OF DECEASED (Type or Print): KATIE L. TIERNEY

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 132 E. Birckhead St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 132 E. Birckhead St. 24-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | May 10, 1872 | 77 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| housewife | at home | Baltimore, Md. | |

13. FATHER'S NAME: William L. Batchelor

14. MOTHER'S MAIDEN NAME: Sarah Jane McCrady

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Marguerite Hirsch | 132 E. Birckhead St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Broncho Pneumonia one week

DUE TO

(B) acute Gall Bladder disease 10 days

DUE TO

(C) arteriosclerosis

senility

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 12, 1949, *to* Dec 23 1949, *that I last saw the deceased alive on* 12/23/49, 1949, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Miller M.D. | 1200 Charles ST | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/23/49 | Cedar Hill Cem. | Washington, D. C. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949

REGISTRAR: Thomas Williams, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS-150 (Rev.)

127B

G81130 ✓ 12/22/49 G81130

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): CHARLES W. SENER

2. DATE OF DEATH: 12/22/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2935 Erdman Ave.

c. Length of stay in Baltimore: 55 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D STREET ADDRESS (If rural, give location): 2935 Erdman Ave. 8-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | widower | Dec. 22nd, 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tinotype Operator | News retired 11yrs. | Pa. | USA |

13. FATHER'S NAME: Fred Sener

14. MOTHER'S MAIDEN NAME: Mary Bowers

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 220-05-9803 A | Mr. Robert W. Sener | 2935 Erdman Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardio Vascular Heart dis. | 3 yr. |
| DUE TO (B) | Myocardial failure | 3 days. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 1948 *to* 12-22, 1949 *that I last saw the deceased alive on* 12-22, 1949 *and that death occurred at* 7P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Fearn M. D. | 3025 Belair Road | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/26/49 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams M.D. | Lassahn Funeral Home | 7401 Belair Rd. |

VS 150

93D

FICATE CORRECTED 12-23-49

G81131
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81131
Registered No.

1. NAME OF DECEASED (Type or Print): Edith MARY ARNOLD
2. DATE OF DEATH: December 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2224 Fredrick Ave
C. Length of stay in Baltimore: 74 YRS (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY: BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE, MD.
D. STREET ADDRESS (If rural, give location): 2224 FREDRICK Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | WIDOWED | June 2, 1874 | 75 74 YRS | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife, | OWn home | MARYLAND | USA |

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: MARION L. Reed

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Miss ELsie WARNOLD BALTO |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis & Myocardial degeneration Rt Rheumatic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C) Generalized Arteriosclerosis ?

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* October 1, 1949, *to* December 22, 1949, *that I last saw the deceased alive on* Dec 22, 1949, *and that death occurred at* 10.35A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M. D. | 2030 W. Fayette St | 12/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Loudon Park | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 23 1949 | Tunstall for Williams, M.D. | Wm Cook Inc. 1217 St. Paul St. |

VS 150

937

G81132

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

150.0

G81132

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Anna Katherine Pistel

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 42 N. Bentalou St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | W | Widowed | Aug. 10, 1863 | 86 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George Gundlach
14. MOTHER'S MAIDEN NAME: Katherine Truss
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Louis G. Pistel ADDRESS: 42 N. Bentalou St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Bronchopneumonia | 1 wk |
| DUE TO | (Pathologic) | |
| (B) | Fracture rt. femur; senility | 2 mos. |
| DUE TO | (Senile osteoporosis) | |
| (C) | Arteriosclerosis | 10 yrs. |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.):
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Mar, 1948 *to* 12-21-, 1949 *that I last saw the deceased alive on* 12/15, 1949, *and that death occurred at* 8:00 Pm, *from the causes and on the date stated above.*

23A. SIGNATURE: Robt. B. Wright M.D.
23B. ADDRESS: Medical Arts Bldg.
23C. DATE SIGNED: 12/23/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-24-49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Lucy for Williams, M.D.
25. FUNERAL DIRECTOR: Frank G. Cole ADDRESS: 1913 W. Balto St.

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G81133 G81133

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles Lambert Hackett

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 120 N. Payson St.

c. Length of stay in Baltimore: 20 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 120 N. Payson St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | Married | June 14, 1885 | 64 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10B. KIND OF BUSINESS OR INDUSTRY: U. S. Govt.

11. BIRTHPLACE (State or foreign country): Baltimore County

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT: Louise B. Hackett ADDRESS: 120 N. Payson St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

DUE TO

(B) Arteriosclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 15, 1949, to Dec. 20, 1949, *that I last saw the deceased alive on* Dec. 20, 1949, *and that death occurred at* 1:35 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Clive Laughlin M. D.

23B. ADDRESS: 4508 Edmondson Village

23C. DATE SIGNED: 12/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-23-49

24C. NAME OF CEMETERY OR CREMATORY: Loudon Park

24D. LOCATION (City, town, or county) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Frederick A. Cole ADDRESS: 1913 W. Baltimore St.

VS 150

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G81134 Walter ✓ E916.0 G81134

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Riggin — N-948 — 2. DATE OF DEATH 12-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West. Baltimore Gen. Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3400 W. North Ave. N-06

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | DIVORCED | | 45 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Painter | | Maryland | U.S.A. |

13. FATHER'S NAME Ouizer Riggin
14. MOTHER'S MAIDEN NAME Minerva

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Hospital Records | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Toxemia
DUE TO
(B) 2nd 3° Burns of body & extremity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
Dr. J. R. Davis per
B K Fowler M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) A | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3400 W. North Ave. |
|---|---|---|
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 27 49 11 p.m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? Lighted cigarette onto mattress Fire at home |

22. *I hereby certify that I attended the deceased from* 11-27-49, 19__, *to* 12-22-49, 19__, *that I last saw the deceased alive on* 12-22-49, 19__, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Bowie Lynn Grant M.D. M.D. | W.B.G. Hosp. | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Asbury Cem. | Crisfield, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | John F. Denny, Inc. | 715 Light St-30. |

VS 150

180

G81135

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G81135

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): Ellison, Louis

2. DATE OF DEATH: 12-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 120 N. Rossuth St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | White | Married | 6-11-1889 | 62 | 6 | 10 | 22 | 28 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None. | | Russia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| I. Ellison | Unknown |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

DUE TO

(B) Coronary Artery Sclerosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* December 1949 *to* 12-22, 1949, *that I last saw the deceased alive on* 12-22, 1949 *and that death occurred at* 10:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Isaac Bakwin M. D. | Franklin Sq. Hosp. | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Hebrew Friendship | Dallas Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Tuttington Williams, M.D. | Jack Levin Inc | 2100 Eutaw Pl |

VS 150

94a

G81136

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 33

Registered No. G81136

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BENJAMIN SCHERR
2. DATE OF DEATH: 12-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3007 Oakley Ave
C. Length of stay in Baltimore: 54 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3007 Oakley Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | | 62 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Tailor | Clothing | Russia | |

13. FATHER'S NAME: Louis
14. MOTHER'S MAIDEN NAME: Etta

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Helen Scherr | 3007 Oakley Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO
(B)
DUE TO
(C) Cerebral + generalized arteriosclerosis 25 yrs

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12/16 1949 to 12/23 1949, that I last saw the deceased alive on 12/22 1949, and that death occurred at 3:45 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| B. Maurice Feldman M.D. | 817 St. Paul St. | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Bnai Israel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eutaw Pl |

VS 150

107

G81137

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81137

1. NAME OF DECEASED (Type or Print): Soh Silver

2. DATE OF DEATH: 12-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3841 Foarman ave

C. Length of stay in Baltimore: 36 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3841 Foarman Ave

5. SEX: Male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (specify): married
8. DATE OF BIRTH:
9. AGE (If under 1 year, Months, Days; If under 24 hours, Hours, Min.): 57
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): agent
10B. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Ruth
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Edzor
14. MOTHER'S MAIDEN NAME: Anda
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Goldie Silver ADDRESS: 3841 Foarman Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 9 months

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 9/10/49
19B. MAJOR FINDINGS OF OPERATION: Biopsy showed carcinoma cells
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about house, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/15 19 49 to 12/23 19 49, *that I last saw the deceased alive on* 12/22 19 49, *and that death occurred at* 2:07 m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 2310 Eutaw Pl
23C. DATE SIGNED: 12/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-25-49
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

47D

G81138

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81138

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SADIE GREENFELD

2. DATE OF DEATH: 12-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3111 Oakley Ave

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 34
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Klein Leavey
14. MOTHER'S MAIDEN NAME: Mary

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Samuel Greenfeld
ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Brain tumor (malignant)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

19A. DATE OF OPERATION: 4 yrs ago
19B. MAJOR FINDINGS OF OPERATION: Brain tumor
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____ 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____ 19__, *and that death occurred at* 7:00 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: W. E. Reade M.D.
23B. ADDRESS: 3131 Wilson Blvd
23C. DATE SIGNED: 11/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-23-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Law
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Cunningham Williams, M.D.
25. FUNERAL DIRECTOR: Jack Reeves Jr
ADDRESS: 2100 Eutaw Pl

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G81139

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81139

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROSE STEIN

2. DATE OF DEATH: 12-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale

C. Length of stay in Baltimore: 50 Yrs. ~~Mos.~~ ~~Days~~

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Levindale

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH:
9. AGE (In years last birthday): 90
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia | 3 days |
| | | DUE TO | |
| | ANTECEDENT CAUSES | | |
| | DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | | DUE TO | |
| II | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) Chronic cardio-vascular disease | Years |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-16 1942 *to* 12-22, 1949 *that I last saw the deceased alive on* 12-22, 1949, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry Nagel M. D.
23B. ADDRESS: Levindale Home
23C. DATE SIGNED: 12-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-23-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Mt. Carmel
24D. LOCATION (City, town, or county) (State): Butler Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

937

MS—134163 G81140

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81140 Registered No. 177

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Albert Methias Warrenberger

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 504 Albemarle St. Zone 2

3-C

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct. 16, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: George W. Warrenberger (Deceased)

14. MOTHER'S MAIDEN NAME: (Deceased) Susie S. Trumbo

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | none | Baltimore City Hospitals Records—4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. 177 X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bilateral hydronephrosis ~~Bronchial pneumonia~~

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Obstruction of ureters

DUE TO

(C) Carcinoma of prostate

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: ~~Carcinoma of prostate—~~ ~~CVA—Cerebrovascular accident~~

INTERVAL BETWEEN ONSET AND DEATH: over

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-13-49 | Urinary obstruction | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-12- , 19 49 *to* 12-21- , 19 49 *that I last saw the deceased alive on* 12-21- , 19 49 *and that death occurred at* 7:35P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | B.C.H.—4940 Eastern Ave. | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-24-49 | Western | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 23 1949 | Thurston for Williams, M.D. | G. Howard Strong 3207 W. North Ave. |

VS 180

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G81141

BALTIMORE CITY HEALTH DEPARTMENT 1 93

# CERTIFICATE OF DEATH

G81141

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Eleaner Mason

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2913 Denham Circle

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: 25 - 3[illegible]
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore (Cherry Hill)
D. STREET ADDRESS (If rural, give location): 2913 Denham Circle

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Married | Oct. 15 1911 | 38 | 2 5 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | — | Buckingham County, VA | U. S. A. |

13. FATHER'S NAME: Battle Banks.

14. MOTHER'S MAIDEN NAME: MATTIE BANKS

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no. | — | — | Steve Mason | 2913 Denham |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malignancy of Brain — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 mo.

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Called to Patient Dead; Signed after permission from Coroner's Office, 19__, to 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at 11:45 A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerry L. Tucker M. D. | 427 Swale ave | 12/20/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 24, 1949 | Mt. Auburn | Baltimore md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Mrs. Katie R. Wellons | 3224 Edmondson |

VS 150

548

81142

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

G81142

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edith Minnie Williams

2. DATE OF DEATH: Dec-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2410 Annapolis Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2410 Annapolis Ave

C. Length of stay in Baltimore: 29 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 75-33
D. STREET ADDRESS (If rural, give location): 2410 Annapolis Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | negro | married | Febr-2-1901 | 48 | — | | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | | Silman South Carolina | U.S.A. |

13. FATHER'S NAME: Steven Hill

14. MOTHER'S MAIDEN NAME: Rachel Harrel

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | not known | Georgiana Williams | 2410 Annapolis Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cancer of the Stomach — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) ___ DUE TO
(C) ___

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: about one year.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Jan-31-49 | Ca of Stomach | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* August 19 49 to Dec-21- 19 49, *that I last saw the deceased alive on* Dec-21- 19 49, *and that death occurred at* 9 30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walther H. Sonnenfeldt M.D. | 2708 Tollins Ferry Rd | 12-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 24 1949 | Mt. Auburn | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams M.D. | Mrs Katie R Williams | 3225 Schroeder |

VS 150

46B

G81143

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 584 G81143

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ELIZA P ANDERSON

2. DATE OF DEATH: 12-22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MARYLAND GENERAL HOSP.
c. Length of stay in Baltimore: 65 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~3410 GARRISON~~ BALTIMORE 16
D. STREET ADDRESS (If rural, give location): 3410 GARRISON BLVD 15-10

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | WHITE | WIDOWED | 5-31-84 | 65 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | HOME | MARYLAND | U.S.A. |

13. FATHER'S NAME: EDWARD PARRISH

14. MOTHER'S MAIDEN NAME: Sabia HENDERSON

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| - no | no | MRS. GEORGE BROWN | 3714 BARRINGTON RD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic shock | 6 hrs |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Upper G.I. tract Hemorrhage | 8 hrs |
| DUE TO | | |
| (C) | Undefined lesion | 6 mo |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertensive C.V.D<br>Chronic Cholecystitis | 10 yrs<br>1 yr |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-21-49 | CHRONIC CHOLECYSTITIS & CHOLELITHIASIS | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/13, 1949 *to* 12/22, 1949, *that I last saw the deceased alive on* 12/22, 1949, *and that death occurred at* 6 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul S. Herold M.D. | Maryland General Hospital | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Bethel Cem. | Harford Co., Md. |

DEC 23 1949

REGISTRAR'S SIGNATURE: Thurlington for Millemann, M.D.

25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

126

G81144

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 43

G81144

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): LEONARD F. HACHTEL

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2601 Roslyn Ave.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 4 St. Martin's Rd. 12-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | June 16, 1868 | 81 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Office Mgr. (rtd) | Transfer Co. | Balto., Md. | |

13. FATHER'S NAME: Charles Hachtel

14. MOTHER'S MAIDEN NAME: Hedwig Henrietta Zeller

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | | Mrs. Herbert Roberts - 4 St. Martins Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 12 days |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | OUE TO (B) Hypertensive Cardiovascular Disease | ? |
| | OUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Generalized Arteriosclerosis | ? |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Jan 47, *to* Dec 49, *that I last saw the deceased alive on* Dec 21, 1949, *and that death occurred at* 8:40 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John M. Scott M.D. | 8 Longwood Road | Dec 22 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

G81145

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81145

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROBERT LEE BROOKS

2. DATE OF DEATH: Dec. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2803 Woodbrook Ave.
c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2803 Woodbrook Ave. 12-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Sept. 12, 1889 | 60 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| chauffeur | Taxi | Cambridge, Md. | |

13. FATHER'S NAME: -

14 MOTHER'S MAIDEN NAME: -

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| - | | | Mrs. Myrtle Brooks | 2803 Woodbrook Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | 12-21-49 |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Chr. Myocarditis | 1947 |
| DUE TO | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. (C) | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1- 1949 *to* Dec. 22 1949 *that I last saw the deceased alive on* Dec 22, 1949 *and that death occurred at* 6:00 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| James Brown M. D. | 1663 W. North Ave. | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12.24/49 | Glen Haven Cem. | Anne Arundel Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

G81146

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81146

BIRTH NO.

Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) | JOHN B. GIRARDIN |
| 2. DATE OF DEATH | Dec. 21, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) | 2932 Guilford Ave. |
| c. Length of stay in Baltimore (Yrs. Mos. Days) | |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE | Md. |
| B. COUNTY | |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | Baltimore |
| D. STREET ADDRESS (If rural, give location) | 2932 Guilford Ave. 12-07 |
| 5. SEX | male |
| 6. COLOR OR RACE | white |
| 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | married |
| 8. DATE OF BIRTH | Nov. 4, 1876 |
| 9. AGE (In years last birthday) / If Under 1 Year Months / Days / If Under 24 Hours Hours / Min. | 73 yrs. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | Consultant |
| 10B. KIND OF BUSINESS OR INDUSTRY | Hearing Aid |
| 11. BIRTHPLACE (State or foreign country) | Balto., Md. |
| 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | Emil Girardin |
| 14. MOTHER'S MAIDEN NAME | Mary E. Christian |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | no |
| 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT / ADDRESS | Mrs. Lillie Girardin - 2932 Guilford Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardio. Vascular disease | 10 months |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis | ? |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* March 16, 1949 *to* Dec. 21, 1949, *that I last saw the deceased alive on* Dec 21, 1949, *and that death occurred at* 8:20 P. m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE | A. Wilbur Stewart M. D. | 23B. ADDRESS: 6 E. Read St. Balto-2. Md. |
| 23C. DATE SIGNED | 12/22/49 | |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | Burial | |
| 24B. DATE | 12/24/49 | |
| 24C. NAME OF CEMETERY OR CREMATORY | Lorraine Cem. | |
| 24D. LOCATION (City, town, or county) (State) | Woodlawn, Md. | |
| DATE RECEIVED BY LOCAL REGISTRAR | DEC 23 1949 VS 188 | |
| REGISTRAR'S SIGNATURE | Huntington Williams, M.D. | |
| 25. FUNERAL DIRECTOR / ADDRESS | WM. J. TICKNER & SONS Balto., Md. | |

93D

G81147

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1949 G81147 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Weston Walter Seward

2. DATE OF DEATH: Dec. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3315 Mondawmin Ave. 15-37

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | widowed | Oct. 13, 1874 | 75 yrs. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Guard | Arundel Brook Corp | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Elliott Seward | Dorothy Dykes |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Miss Evelyn M. Stewart | 3315 Mondawmin Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Lymphosarcoma | 7 mos. |
| | DUE TO (B) | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 11, 1949 *to* Dec. 22, 1949 *that I last saw the deceased alive on* Dec. 22, 1949, *and that death occurred at* 1:20 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward J. Rudolf Jr. M. D. | Mercy Hospital | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/26/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Tunstington Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

55E

G81148

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 924.0

Registered No. G81148

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MONA SHARP N-991

2. DATE OF DEATH: December 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 639 Vincent Street 16-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | — | Dec 7 1949 | | 19 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Balto Md | |

13. FATHER'S NAME: Vance Sharp

14. MOTHER'S MAIDEN NAME: Romaine E Jackins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Vance Sharp ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Suffocation | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 639 Vincent Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 22, 1949 Pm. | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Bedclothes |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: Carl L Snyder M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED: 12-22-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | | Mt Calvary Cem | A.A. Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Contington Williams, M.D. | Mrs Robert A. Elliott & Daughter | 1129 N. Carlton St |

182a

VS 151

G81149

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 G81149

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): EVELYN ROGERS

2. DATE OF DEATH: 12-20-49.

3. PLACE OF DEATH:
a. Baltimore City, Maryland 1705 Presstman St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 5 yrs

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1705 Presstman St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | Col. | M | Nov. 5, 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Jessie Harris

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Elan Rogers | 1705 Presstman St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive Heart | 2 years. |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-15-, 1949 *to* 12-20-, 1949, *that I last saw the deceased alive on* 12-19 1949, *and that death occurred at* 2:20 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George C. Page M.D. | 1516 N. Mount St | 12-23-49. |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-24-49 | Mt Calvary | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, MD | George G. Kelson | 1303 Eastern Ave |

VS 150

93D

G81150

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81150

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHANNA FRETT

2. DATE OF DEATH: December 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 773 W. Lexington St. 4-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | ? | | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | | ? | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Catholic Charities | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardio-vascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Wm. J. McClafferty M.D. | | Dec. 22, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Dec 23-49 | Sacred Heart | Germantown Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | J. J. Fahy & Son | 1318 Light St |

VS 151

929

G81151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G81151

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Wm. L. KIRSCH

2. DATE OF DEATH Dec. 22. 49.

3. PLACE OF DEATH
A. Baltimore City, Maryland 6003 EDNA AVE

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — —

c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
6003 EDNA AVE
C. CITY OR TOWN (If outside corporate limits, write RFD, and give township) BALTIMORE Md.
D. STREET ADDRESS (If rural, give location) 6003 EDNA AV.

5. SEX M

6. COLOR OR RACE W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWER.

8. DATE OF BIRTH May 16 1886

9. AGE (In years last birthday) 63 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) BALTO Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME JOHN L. KIRSCH

14. MOTHER'S MAIDEN NAME Eliz. J. Sapp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-09-0304

17. INFORMANT MRS PRESTON ADDRESS 6003 EDNA AV.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary occlusion | 12 Mos. |
| DUE TO | Coronary sclerosis | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST (B) | | |
| DUE TO | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Bronchitis & Hay Fever. | 5 yrs. |

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT SUICIDE HOMICIDE (Specify)

21B. PLACE OF INJURY (In or about home, farm, factory, street, office, bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* Jan. 20, 1949 *to* Dec. 22 1949 *that I last saw the deceased alive on* Dec. 22 1949 *, and that death occurred at* 11 A. m. *, from the causes and on the date stated above.*

23A. SIGNATURE Gilbert L. Fitzgerald M.D.

23B. ADDRESS 1613 E. North Ave.

23C. DATE SIGNED 12-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL.

24B. DATE Dec. 24. 49.

24C. NAME OF CEMETERY OR CREMATORY BALTO. Cem.

24D. LOCATION (City, Town or County) (State) BALTO. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR L. HECHMANN & SON

ADDRESS 6467 HARFORD Rd.

VS 150

94a

G81152 54.4 G81152

BIRTH NO. 49-20627

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): GEORGE R. FOWLER JR.

2. DATE OF DEATH: 12-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 300 S. Fulton Ave

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | single | 9-22-1949 | 3 | 3 / 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto Md | |

13. FATHER'S NAME: George R. Fowler
14. MOTHER'S MAIDEN NAME: Madeleine Fowler

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| | | | Madeleine Fowler 300 S Fulton Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) ATELECTASIS LEFT LUNG — DUE TO

(B) CARDIAC HYPERTROPHY — DUE TO

(C) TERMINAL FEBRILE

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [4] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12/22, 1949 *to* 12/28, 1949, *that I last saw the deceased alive on* 12/23, 1949, *and that death occurred at* 3:20 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M.D. | [illegible] | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Loudon Park | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | for H. B. M. Walters Pratt & Lyndon Sts |

VS 150

157E

G81153

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81153

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret Tuerk

2. DATE OF DEATH: 12/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: XXXXX 70 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 29
D. STREET ADDRESS (If rural, give location): 4905 Parkton Ave. 25 - 31

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9/17/1872
9. AGE (In years last birthday): 77 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work, describing most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Germany -
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Conrad Aull ? (dec'd)
14. MOTHER'S MAIDEN NAME: Katherine?? (dec'd)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Evelyn Smeltzer ADDRESS: 3905 Dolfield Ave-15

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(B) Arteriosclerotic CVD — ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/19 *1949 to* 12/21 *1949 that I last saw the deceased alive on* 12/21 *1949, and that death occurred at* 11:15 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Robert J. Sinclair M. D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 12/22/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/24/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.
BALTIMORE - 13, MD.

VS 150

931

G81154

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81154

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Pansy Lee Slaysman

2. DATE OF DEATH: Dec 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3714 Monterey Road

C. Length of stay in Baltimore: 53 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3523 Cliftmont Avenue 26-03

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widow
8. DATE OF BIRTH: Apr. 26, 1886
9. AGE (In years last birthday): 63 (If under 1 Year: Months / Days; If under 24 Hours: Hours / Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ? Thompson
14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT ADDRESS: 3714 Monterey Rd.
Mrs. Louis Hasslinger

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary occlusion
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY — m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: William B Helfrich M.D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12-22-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 12/26/49
24C. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: HENRY SANDER & SONS, INC.

VS 151

94a BALTIMORE - 13, MARYLAND

681155

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 681155

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Roberta Bryan — 2. DATE OF DEATH: Dec. 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 937 N. Stricker St.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 16-07
D. STREET ADDRESS (If rural, give location): 937 N. StrickerSt.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Married | June 21-14 | 35 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Harry Broom
14. MOTHER'S MAIDEN NAME: Carrie Goss

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| | | 937 N. Stricker St |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Myocardial degeneration—? Thyro-toxic | |
| DUE TO | heart disease | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| W. J. McClafferty M.D | | Dec. 21, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Galesville Md | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Sarah L. Brown | 108 W Montgomery St |

VS 151

63B

G81156

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

759.0

Registered No. G81156

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND FORREST

2. DATE OF DEATH 12/21/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST BALTO. GEN. HOSP.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md B. COUNTY Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Middleburgh

D. STREET ADDRESS (If rural, give location) Hyde Park

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | S | Oct. 22-1947 | 2 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Roland E. Forrest Jr.

14. MOTHER'S MAIDEN NAME Alice M Huntington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)

16. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Parents ADDRESS Same as Above

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) CHRONIC COR PULMONALE

DUE TO

(B) FIBROCYSTIC DISEASE OF

DUE TO LUNG AND PANCREAS

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/10/, 19X9 *to* 12/21/, 19X9 *that I last saw the deceased alive on* 12/21/, 19X9 *and that death occurred at* 0:10 AM *from the causes and on the date stated above.*

23A. SIGNATURE [signature] M. D.

23B. ADDRESS 103 E St

23C. DATE SIGNED 12/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12-24-49

24C. NAME OF CEMETERY OR CREMATORY Moreland Park

24D. LOCATION (City, town, or county) (State) Balto Co Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 23 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR John J. Connolly

ADDRESS 415 Eastern Ave Balto 24 Md.

128

VS 150

G81157

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81157

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Walden Keller Gorsuch

2. DATE OF DEATH: Dec 22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 4124 Westview Rd

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at Home

c. Length of stay in Baltimore: Yrs. Life; Mos.; Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Balto City
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-09
D. STREET ADDRESS (If rural, give location): 4124 Westview Rd. (B)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Aug-21-1893 | 56 yrs | - | - | - | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant- | Shoes Mfg. | Balto. Md. | U.S. |

13. FATHER'S NAME: Geo. F. Gorsuch

14. MOTHER'S MAIDEN NAME: Anna S. Keller

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Yes W.W.I | - NONE - | Mrs Ethel C. Gorsuch-wife | Balto |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | Immediate |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Arteriosclerosis | Indefinite |
| DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* July, 1940 to Dec 22, 1949 *that I last saw the deceased alive on* Dec 22, 1949, *and that death occurred at* 8:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathaniel M Beck MD M. D. | 100 E 23rd St Balto 18 Md | Dec 23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec-24-49 | Lorraine | Woodlawn |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Emerson Williams, M.D. | Stewart Moore Co | Balto Md |

VS 150

94a

G81158

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81158

Registered No.

1. NAME OF DECEASED (Type or Print): ELIZABETH NORRIS ALBAUGH NEWPORT

2. DATE OF DEATH: Dec. 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2305 N. North Ave.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D STREET ADDRESS (If rural, give location): 2305 N. North Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | white | widowed | Dec. 3, 1860 | 89 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - | | Woodbine, Carroll Co., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James A. Albaugh | Ann Virginia Norris |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| - | - | Mrs. Bessie Crook | 3215 Dorchester Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic myocarditis + Arter. Sclerosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: yrs

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 1, 1944 *to* Dec 21, 1949 *that I last saw the deceased alive on* Dec 20/49, 19__ *and that death occurred at* 10-20 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Allen C Hancock M. D. | 1923 W North Ave | 12/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Pottsmann, Mgr | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

G81159

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4720.0 G81159

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LOUIS ALEXANDER YOUNG

2. DATE OF DEATH: Dec. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3917 W. Garrison Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3917 W. Garrison Ave. 27-16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | Mar. 13, 1881 | 68 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Contractor | Contracting | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Young | Carrie A ? |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Miss Gladys Young | 3917 W. Garrison Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral vascular accident | 1 day |
| DUE TO (B) | Arteriosclerotic Heart Disease | 2 yrs. |
| DUE TO (C) | with Coronary Sclerosis Pulmonary emphysema & fibrosis | 2 yrs |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* October 19, 1947 *to* Nov 22, 1949, *that I last saw the deceased alive on* Nov 22, 1949 *and that death occurred at* 6.30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Nathan E. Lowman M. D. | 4843 Park Heights Ave | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

G81160 ✓ X 3 G81160

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FANNIE J. BUMBAUGH

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parkville
D. STREET ADDRESS (If rural, give location): 7906 Old Harfori Rd.

5a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2316 E. Preston St.

5c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: June 2, 1900
9. AGE (In years last birthday): 49 yrs. If under 1 year: Months Days. If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: own Home
11. BIRTHPLACE (State or foreign country): Howard Co., Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James A. King
14. MOTHER'S MAIDEN NAME: Margaret Toms

15. WAS DECEASED EVER IN U. S ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: no

17. INFORMANT: Mr. Archie D. Bumbaugh ADDRESS: 7906 Old Harford Rd. Parkville

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of descending colon.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 1948 *to* Dec. 23, 1949, *that I last saw the deceased alive on* Dec. 22, 1949 *and that death occurred at* 3.40 P.M. *m., from the causes and on the date stated above.*

23A. SIGNATURE: K. A. Gott M. D.
23B. ADDRESS: 8100 Harford Rd.
23C. DATE SIGNED: 12/23/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/27/49
24C. NAME OF CEMETERY OR CREMATORY: Greenhill Cem.
24D. LOCATION (City, town, or county) (State): Waynesboro, Pa.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

VS 150

46E

G81161

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81161

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LULU UPMAN

2. DATE OF DEATH 12/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University of Maryland Hospital

c. Length of stay in Baltimore Year / Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Howard.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elkridge.
D. STREET ADDRESS (If rural, give location) —

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married. | 4/26/1879 | 70. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housework | | New Jersey. | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Eugene Babcock. | Lodina Eaglestone |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Mrs Wm Sheets | — |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion

DUE TO

(B) arteriosclerotic heart disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 10/27, 1949 to 12/22, 1949, that I last saw the deceased alive on 12/22, 1949, and that death occurred at 5:35 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Mark E. Hall, M. D. | Elk Md Hospital | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. | Meadowridge Memorial Park | Washington Blvd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Easton Sons | Catonsville, Md |

VS 150

937

G81162
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81162
Registered No.

1. NAME OF DECEASED (Type or Print): Sister Bernado Feldhaus
2. DATE OF DEATH: Dec. 22, 49

3. PLACE OF DEATH:
a. Baltimore City, Maryland 901 Aisquith Street
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Notre Dame Convent
c. Length of stay in Baltimore 1 yr. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 901 Aisquith Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Oct. 24, 1876 | 73 | 1 / 28 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | Religious Teacher | Germany | U.S.A. |

13. FATHER'S NAME: Bernard Feldhaus
14. MOTHER'S MAIDEN NAME: Magdalen Cardell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Sr. M. Stan. Kostka | 901 Aisquith Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infiltrating Paranomalefts
DUE TO
(B) Breast-Metastases in
DUE TO Mediastinum
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* October, 1948, *to* December, 1949, *that I last saw the deceased alive on* Dec. 16, 1949, *and that death occurred at* 7.50 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis J. Kirby M. D. | 110 E. North Ave | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 24 49 | Mount Olivet | Glen Arm |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Geo. M. Frank & Son | |

VS 150

50

G8L163

BALTIMORE CITY HEALTH DEPARTMENT E 902 ° G8L163

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Sister Mary Clarence Hirst Nun

2. DATE OF DEATH Dec. 22. 49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital

c. Length of stay in Baltimore 20 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Notre Dame College
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4701 N. Charles Street 27-11

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | April 2, 1867 | 82 | 8 | 20 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Teacher | | Hecker, Illinois | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Hirst | Ellen Bamber |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Sr. M. Peter Fournier | Notre Dame College |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pneumonia, Bronchial, Bilateral | 11 days. |
| DUE TO (B) | Fracture, Left Hip | 20 days. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12/6/49 | Fracture, Left Hip | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Notre Dame College | Notre Dame College. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 12/2/49 @ 10 A.M. | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Fell out of bed while sleeping. |

22. *I hereby certify that I attended the deceased from* 12/2, 1949, *to* 12/22, 1949, *that I last saw the deceased alive on* 12/22, 1949, *and that death occurred at* 9:25 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph R. Dolce, M.D. | Bon Secours Hospital | 12/22/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 26/49 | Notre Dame Chapel | Mt. St. Charles |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | Geo. McGuire & Son | |

VS 150

186a

G81164

G81164

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E978.0

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM JORDAN N-806.2

2. DATE OF DEATH: December 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 201 N. Carey Street 18 02

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | Mar. 23 | 26 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Radio Technician | | Belford, Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Jordan | Susan |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Daisy J. Jordan | 2012 N. Carey St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary hemorrhage — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Compression, fracture of dorsal spine — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | home | 201 N. Carey Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 22, 1949 1:30A | WHILE AT WORK [ ] NOT WHILE AT WORK [X] | Jumped from third story window |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ] suicide [X], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Royer M.D. | X | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 26, 1949 | Fairmount Cemetery | Bedford, Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Lucretia for Williams, M.D. | Mrs Katie R. Williams & Son | 322 N |

VS 151

164E

G81165

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81165

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN J. NOCTOR

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2648 Guilford Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 2648 Guilford Ave 12-20

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | Married | 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | Auto. Industry | Baltimore, Md. | |

13. FATHER'S NAME: James Noctor

14. MOTHER'S MAIDEN NAME: Mary Ann Byrn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| no | - | |

17. INFORMANT: Mrs. E.M.Noctor ADDRESS: 2648 Guilford Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Congestive heart failure | several yrs |
| DUE TO | (B) Arteriosclerotic heart disease | several yrs |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Cirrhosis & diabetes mellitus | 5-6 yrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 12/12, 1949 *to* 12/20, 1949, *that I last saw the deceased alive on* 12/20, 1949 *and that death occurred at* 12:05 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William J. Penner M. D. | 11 W. 29th St. | 12/21/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-23-49 | Holy Redeemer | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Interpreter Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

VS 150 DEC 23 1949

61

G81166

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

466 Registered No.

G81166

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jeanetta M. Walkling

2. DATE OF DEATH: Dec. 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.
C. Length of stay in Baltimore: 21 Years / Months / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): 57 W Greene St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | widowed. | Jan 23 1895 | 54. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife. | | Maryland. | |

13. FATHER'S NAME: Frederick Magin.

14. MOTHER'S MAIDEN NAME: Katherine Miner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Edema. | 18 hr. |
| DUE TO (B) | Thrombosis of Jugular Venaca. | 16 days. |
| DUE TO (C) | Thrombosis of femoral and iliac veins | 2½ mo. |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Avitaminosis - Pulmonary infarction - | - |

ANTECEDENT CAUSES — I. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12-2 1949 to 12-23 1949, that I last saw the deceased alive on 12-23 1949 and that death occurred at 5:40 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Patterson Mach M.D. | University Hospital | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 26-49 | Deer Park | Carroll Co |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 24 1949 | Huntington Williams, M.D. | H. Bankard. Inc Westminster Md. |

VS 150

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G81167 BALTIMORE CITY HEALTH DEPARTMENT 446 G81167

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) August Martini

2. DATE OF DEATH 12-21-49

3. PLACE OF DEATH (a) Baltimore City, Maryland

(b) FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

(c) Length of stay in Baltimore 75 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
(a) STATE Maryland (b) COUNTY Baltimore
(c) CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dundalk 26-06
(d) STREET ADDRESS (If rural, give location) 6562 Fairhill Avenue

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Sept. 19, 1878

9. AGE (In years last birthday) 71 If under 1 Year: Months Days; If under 24 Hours: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Chemist

10b. KIND OF BUSINESS OR INDUSTRY Chemical Pigment

11. BIRTHPLACE (State or foreign country) Baltimore

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Albert Martini

14. MOTHER'S MAIDEN NAME Elizabeth Zimmerman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Hospital Records ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Renal failure | 4 days |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Senile arteriosclerotic nephrosclerosis | unknown |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | — | |

19a. DATE OF OPERATION No

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) No

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14, 1949 *to* 12-21, 1949 *that I last saw the deceased alive on* 12-21, 1949, *and that death occurred at* 10:35 *m., from the cause and on the date stated above.*

23a. SIGNATURE H. Mitchenor M.D.

23b. ADDRESS Church Home Hospital

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 23, 1949

24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery

24d. LOCATION (City, town, or county) (State) Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 23 1949

REGISTRAR'S SIGNATURE Carrington Williams, M.D.

25. FUNERAL DIRECTOR ADDRESS Roland L. Fisher, 2112 Dundalk Ave.

VS 150

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MS—132956
G81168

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81168

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jane Vera Betts

2. DATE OF DEATH 12-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore none (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL—Doubs
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | May 19, 1946 | 3 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Leroy Betts

14. MOTHER'S MAIDEN NAME Virginia Hesplanf

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Baltimore City Hospitals Records—4940 Eastern Ave.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

16. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Tuberculous Meningitis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 10-27- , 1949, *to* 12-23- , 1949 *that I last saw the deceased alive on* 12-23- , 1949 *and that death occurred at* 12:05AM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. L. Rozen M. D. | B.C.H.—4940 Eastern Ave. | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-27-49 | Mt. Olivet Cemetery | Frederick - Md. |

| DATE RECEIVED | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | Huntington Williams, M.D. | C. E. Cline + Son | Frederick - Md. |

VS 150

14

G81169

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81169

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARIE Estella HERFURTH

2. DATE OF DEATH: 12-23-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 1809 2. Durham Av.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1809 2. Durham St
c. Length of stay in Baltimore: 56 Yrs. 17 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1809 2. Durham St

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: December 6, 1893
9. AGE (In years last birthday): 56 (If under 1 Year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Polston
14. MOTHER'S MAIDEN NAME: Marie Polston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO:
17. INFORMANT: Paul Herfurth ADDRESS: 1809 2. Durham

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-14 1946 *to* 12-14 1949, *that I last saw the deceased alive on* 12-14 1949, *and that death occurred at* 12:45 A.m., *from the causes and on the date stated above.*

23A. SIGNATURE: A. Weiss M. D.
23B. ADDRESS: 1927 E North Ave
23C. DATE SIGNED: 12-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 27th 1949
24C. NAME OF CEMETERY OR CREMATORY: Balto National
24D. LOCATION (City, town, or county) (State): Fredrick Road

DATE RECEIVED BY LOCAL REGISTRAR: DEC 24 1949
REGISTRAR'S SIGNATURE: Winston Williams, M.D.
25. FUNERAL DIRECTOR: Leo F. Leach ADDRESS: 1701-03 N. Patterson Park ave

VS 150

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G81170

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81170

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Michael McCauley

2. DATE OF DEATH: Dec. 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Baltimore

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1200 Valley St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Little Sisters of the Poor Home for the Aged

c. Length of stay in Baltimore: Yrs. 10 Mos. 01 Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M. | W. | W. | Sept 25, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Ireland | |

13. FATHER'S NAME: John McCauley

14. MOTHER'S MAIDEN NAME: Mary Lynch

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Sister Ignatius ADDRESS: 1200 Valley St |
|---|---|---|
| | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Edema Lungs — (INTERVAL BETWEEN ONSET AND DEATH) 2 days

DUE TO

(B) Chronic Myocarditis — 3 yrs

DUE TO

(C) Arterio Sclerosis — 5 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 1 , 1949, to Dec 22 , 1949, *that I last saw the deceased alive on* Dec 22 , 1949, *and that death occurred at* 2:00 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Gil Hall M. D. | 1631 E North Ave | Dec 23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-24-49 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Justin for Williams, M.D. | Rita Wiedefeld | 900 E. Biddle St |

VS 150

937

G81171

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81171

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Irene Butler

2. DATE OF DEATH DEC 22 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore 46 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 137 Aisquith St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widowed | 10-8-03 | 46 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Md | |

13. FATHER'S NAME Henry Smith

14. MOTHER'S MAIDEN NAME Annie Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) POST-OPERATIVE CARDIAC ARREST | 5½ hrs. |
| | DUE TO following extension surgery for | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) CARCINOMA of STOMACH & | 8 mos. |
| | DUE TO extension to transverse colon | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Marked cachexia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12/21/49 | Carcinoma of Antrum of Stomach & Transverse Colon | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-15, 1949 *to* 12-22, 1949 *that I last saw the deceased alive on* 12-22, 1949 *and that death occurred at* 1:55 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frederick M Colomb M. D. | JOHNS HOPKINS HOSPITAL | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-24-49 | mt Olivet | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Treating for Williams, M.D. | Gloyd D Wilson | 1000 Fremont Ave |

VS 150

463

G81172

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

491 Registered No. G81172

BIRTH NO.

1. NAME OF DECEASED (Type or Print): LEATHA JORDAN

2. DATE OF DEATH: 12/19/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 606 N. Mount St.
c. Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MD.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 606 N. MOUNT ST. 16-C 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | WIDOW | 7/17/1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | DOMESTIC | JACKSON, N.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HENRY REID | HENRIETTA DIXON |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | NO | NONE | MEACY JORDAN (D) | 606 N. MOUNT ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronch(e)-Pneumonia | 11/9/49 to 12/19/49 |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Influenza | |
| | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertensive-type H.D. & Chr. Nephritis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| none | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 9/19/49 49 *to* Dec. 19, 19 49 *that I last saw the deceased alive on* Dec. 19 19 49, *and that death occurred at* 4:15 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Evan X Billups M. D. | 601 N. Calhoun St. | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 1/8/1950 | REID CEMETERY | JACKSON, N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Huntington Williams, M.D. | Charles H. Corpus | 512 N. Caroline Av. |

VS 150

1318

681173
B—117060

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 681173

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Adam Gregoski, Jr.

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1619 Cypress St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June 11, 1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Stationary Engineer | Cabaret Booking | Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Adam Gregoski | Theodosia Kopchinski |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | 212-05-7449 | Records--Baltimore City Hospitals 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Sudden death due to? pulmonar y infarct | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pulmonary tuberculosis | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-15-49 | Pulmonary tuberculosis with sinus tract | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 1-30-____, 1948, *to* 12-21-____, 1949 *that I last saw the deceased alive on* 12-21-____ 1949, *and that death occurred at* 10:50 PM *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| O. S. Rogers M. D. | B.C.H.--4940 Eastern Ave. | 12-22-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/26/49 | Holy Cross | A.A. Co. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | [illegible] for Williams, M.D. | E. I. Fanning & Son | 1938 E. Lafayette Ave |

VS 150

1213

G81174

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

80 Registered No.

G81174

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Estelle Merriam Glocker

2. DATE OF DEATH: December 23, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Nursing Home, 3605 Hillsdale Road

c. Length of stay in Baltimore: 22 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4112 Kathland Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | March 1, 1880 | 69 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Philadelphia, Pa. | |

13. FATHER'S NAME: Edward Merriam

14. MOTHER'S MAIDEN NAME: Laura Riday

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | 215-03-4855-A | Mr. Edwin M. Glocker | 5506 Wesley Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Generalized Carcinomatosis | 8 months |
| DUE TO | | |
| (B) | Hypernephroma Rt. | 18 mos |
| DUE TO | | |
| (C) | | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 1948 | Carcinoma Rt. kidney | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Aug 1946 to Dec 23, 1949, *that I last saw the deceased alive on* Dec 20, 1949, *and that death occurred at* 11.35A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr Winsbee Fort M. D. | 20 E. Preston St. | 12/ |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 26, 1949 | Druid Ridge Cemetery | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Registrar for Williams, M.D. | Ellis Funeral | 4510 Liberty Heights Ave. |

VS 150

52a

G81175 ✓ J-9 ✓ G81175

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 2-81160

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret (Maggie) L Brennan

2. DATE OF DEATH: Dec 21/49

3. PLACE OF DEATH: (a) Baltimore City, Maryland

(b) FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1616 E Eager St.

(c) Length of stay in Baltimore: 14 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1616 E Eager St. 2-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | Col. | Widow | Feb 4, 1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Isle of Wight County Va. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Timothy Godwin | Eliza Sarah |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Charles L Brooks | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Nephritis & Uremia — INTERVAL BETWEEN ONSET AND DEATH: 14 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Mental Incompetency and generalized Arteriosclerosis — 14 mos

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 1949 *to* Dec 21, 1949 *that I last saw the deceased alive on* Dec 21, 1949, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph L Young M. D. | 1429 N Monument St | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Dec 23/49 | | Smithfield Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Hunter for Williams, M.D. | Mrs Robert A. Ellis & Daughter | 1129 N. Carrollton Ave |

VS 150

1310

681176

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143

Registered No. 681176

1. NAME OF DECEASED (Type or Print): Charles E. Pirey

2. DATE OF DEATH: Dec. 22-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3102 Baker St

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 3102 BAKER St 16-67

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Mar-4-1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Packer | Butler Bros. | Baltimore-Md. | USA. |

13. FATHER'S NAME: Philip Pirey

14. MOTHER'S MAIDEN NAME: Sophia Mentzel.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Katie E. Pfeiffer. | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive & Arterio Sclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs +

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* January, 1942 *to* 12/22, 1949 *that I last saw the deceased alive on* 12/21 1949, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 3629 Edmondson Ave. 29 | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 24 49 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | [illegible], for Thomas, M.D. | J. Elliffeet & Son | 1800 Eutaw St. |

VS 150

3629—

939

G81177 ✓ No. 1 G81177

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Samuel I. Wright

2. DATE OF DEATH: Dec. 23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 618 Chestnut Hill Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 618 Chestnut Hill Ave. 9-01

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | W. | Married | July 31, 1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Hauling Contractor | Own Business | Balto. Md. | |

13. FATHER'S NAME: Samuel E. Wright

14. MOTHER'S MAIDEN NAME: Bridgit Coughlin

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mrs. Martha P. Wright, ADDRESS: 618 Chestnut Hill Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction) Myocardium
DUE TO arteriosclerotic Coronary Thrombus
(B) Rupture) Myocardium
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: appox 3 Mos.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10/31/49 *to* 12/23/49, *that I last saw the deceased alive on* 12/23/49, *and that death occurred at* 5:00 A m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward W. Mintz, M.D. | 2004 Evergreen Ave | 12/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 26/49 | New Cathedral | 4300 Old Frederick Rd Balto. MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Lentington Williams, M.D. | Harry A. Mintz Co | 4101 Edmondson Ave. |

VS 150

94a

C81178

BALTIMORE CITY HEALTH DEPARTMENT 143

# CERTIFICATE OF DEATH

Registered No. C81178

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY M WATSON

2. DATE OF DEATH DEC 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTO GENERAL HOSP
c. Length of stay in Baltimore LIFE TIME Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE MD
D STREET ADDRESS (If rural, give location) 1110 BURGUNDY ST 21-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| FEM | WHITE | MARRIED | DEC-16-1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | — | BALTO MD | U S |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| CYRUS DRIVER | BLANCH MILLS |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | | WILLIAM H. WATKINS | 1110 BURGUNDY ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral hemorrhage | 1 hour. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (B) Hypertensive cardio vascular disease | 2 years 4 mos. |
| | DUE TO (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — — — | — — — — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — — — | — — — | — — — — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — — — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — — — — |

22. *I hereby certify that I attended the deceased from* 8/21/ , 1947 *to* 12/23/ , 1949, *that I last saw the deceased alive on* 12/23 , 1949 *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Deibel M. D. | 1226 Hanover Street | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-26-49 | HOUDON HILL CEM | BALTIMORE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Emerson Williams, M.D. | Bernard C Hanke | 121 E West St |

VS 150

93D

G81179

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 442

G81179

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CARRIE C. CHESNEY

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 628 Dumbarton Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1827 N. Calvert Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel C. Chesney | Caroline F. Stein |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| no | - | none | 628 Dumbarton Ave Mr. Robt. J. Chesney |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertension Cardiovascular Renal Disease — 2 yrs.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 7, 1949, to Dec 20, 1949, *that I last saw the deceased alive on* Dec 19, 1949, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lloyd E. Saylor M. D. | 2902 Greenmount Av. | Dec 21 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-22-49 | Greenmount Cem | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 24 1949 | Huntington Williams, M.D. | WIRDEFELD & SON | GREENMOUNT AVE & 22ND |

VS 150

131a

G81180

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81180 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Shirley (Haney) Clevenger

2. DATE OF DEATH: Dec. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Med. Obs. 3

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: 15 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: W. Va.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eleanor
D. STREET ADDRESS (If rural, give location): Rural

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 9-29-35 | 14 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | Lewis Co. W. Va | |

13. FATHER'S NAME: Robert Haney

14. MOTHER'S MAIDEN NAME: Iona Stanley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | — | no | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic nephritis

DUE TO

(B) Lupus erythematosus

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-6-, 1949 *to* 12-24-, 1949, *that I last saw the deceased alive on* 12-24-, 1949, *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Leighton E. Cluff M. D. | Johns Hopkins Hospital | 12-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12-24-49 | Eleanor West Va | West Va |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | (Illegible) for (Illegible) | Earl B. Wolverton | 403-E-26th St 12C |

VS 150

G81181

G81181

BIRTH NO. 49-27228

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

760 Registered No.

1. NAME OF DECEASED (Type or Print): Baby Girl Welsh

2. DATE OF DEATH: 12-24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Westbell Gen Hosp

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1903 Lemmon St. 20

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 12-22-49 | | | 42 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | Child | Maryland | |

13. FATHER'S NAME: Earl Edward Welsh

14. MOTHER'S MAIDEN NAME: Margaret Elizabeth RAMSEY

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify which) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | None | None | Earl Welsh | 1903 Lemmon St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C) /

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Breech Presentation

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| — | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* 12-22- 1949 *to* 12-24 1949 *that I last saw the deceased alive on* 12-24-49 *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ernest L. Gray, M. D. | West Baltimore Gen. Hosp. | 12-24-49 |

| 24A. BURIAL, CREMATION OR REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-26-49 | Western | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 25 1949 | Registrar for Commissioner | George F. Schwab | 2101 Frederick Ave. |

VS 150

160a

CERTIFICATE CORRECTED 12-29-49 ✓ G81182

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G81182 Registered No.

1. NAME OF DECEASED (Type or Print) Hugh Amos A. Day

2. DATE OF DEATH 12/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital Baltimore, Md.

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Harford
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Whiteford
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | | Sept. 23, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Electrician | - | Pleasantville, Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George A. Day | Sue Barton |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | 008-07-8612 | Mrs. Eva Day, Whiteford, Maryland |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Myocardial infarction

DUE TO

(C) Coronary occlusion + sclerosis

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-16, 1949 *to* 12-24, 1949, *that I last saw the deceased alive on* 12-24, 1949, *and that death occurred at* 7 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Fred R. McClement Jr. M.D. | University Hospital | 12/29 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Buried | Dec. 28th 1949 | Glen Ridge | Delta, Co. Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 29 1949 | Huntington Titus | Hubert P. Hoffman Delta, Pa. |

VS 15c

94a

G81183 CERTIFICATE CORRECTED 2-6-50 ✓ E-849-4 G81183

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Isaac Birnbaum ~~Birenbaum~~ N-809-4

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

C. Length of stay in Baltimore: 50 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-16
D. STREET ADDRESS (If rural, give location): 4603 Park Heights Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Widower | 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Rag Dealer | Merchant | Russia | USA |

13. FATHER'S NAME: Joseph ~~Birenbaum~~ Birnbaum

14. MOTHER'S MAIDEN NAME: Anna ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. A.A. Weinstock | 4603 Park Heights Ave. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Crushing injury of chest with fractures

DUE TO of sternum and multiple fractures of ribs

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Street | Prospect Hill at Druid Hill Park. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Dec. 23, 1949 2:55 P | WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | Auto into tree 13/4 |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | ~~CHIEF~~ MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | Dec. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 26, 1949 | Hebrew Friendship Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 25 1949 | Huntington Williams | Sol Levinson & Bros | 1126 W North Ave 1700 ✓ |

VS 151

G81184

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81184

BIRTH NO G81184

1. NAME OF DECEASED (Type or Print): HANNAH GUNDERSHEIMER
2. DATE OF DEATH: 12/23/49

3. PLACE OF DEATH
A. Baltimore City, Maryland: Sinai Hospital
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 89 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Baltimore, Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): LAKE DRIVE APRRTMENTS

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| f | w | w | April 14,1860 | 89 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | none | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Iassac Rice
14. MOTHER'S MAIDEN NAME: Kolma Friedenberger

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | none | Felix Gundersheimer | Lake Drive Apts |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
A. arteriosclerotic hypertensive heart disease
DUE TO

II
ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
B.
DUE TO

III
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES NO |
|---|---|---|
| | | |

| 21A. ACCIDENT SUICIDE HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21F. HOW DID INJURY occur? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from 12/22/49 to 12/23, 1949, that I last saw the deceased alive on 12/23, 1949, and that death occurred at 1:05 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William Krakauer M.D. | Sinai Hosp. | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City or County) (State) |
|---|---|---|---|
| BURIAL | Dec. 25, 1949 | Balto., Hebrew | Belair Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 23 1949 | (awaiting for Withdrawal) | David Sondheim Sons | DAVID SONDHEIM & SON 93 D |

- 6 -

G81185

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Reg. No. G81185

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Stella Elizabeth Trostz

2. DATE OF DEATH: 12/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Pa
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Johnston
D. STREET ADDRESS (If rural, give location): 260 Drexel Ave

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Aug 12, 1884
9. AGE (In years last birthday): 65 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alfred Head
14. MOTHER'S MAIDEN NAME: Emma E. Dyer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Miss Janet L Trostz ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Disease | |
| DUE TO | | |
| ANTECEDENT CAUSES (B) | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST — DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒ *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: J. F. Schmidt M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: Dec 25/49
24C. NAME OF CEMETERY OR CREMATORY: Grandview
24D. LOCATION (City, town, or county) (State): Johnstown Pa

DATE RECEIVED BY LOCAL REGISTRAR: DEC 23 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: Henry Hankins & Son ADDRESS: 490 York Rd.

VS 151

Interment in Williamsport 8

94a

BIRTH NO. G81186

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E903.0 G81186 Registered No.

1. NAME OF DECEASED (Type or Print): Sarah Cornelia Fairbank — N-870

2. DATE OF DEATH: Dec 23 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Anderson Convalescent Home 3605 Hillsdale Road
C. Length of stay in Baltimore: 6th — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN: (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location): 2815 N. Calvert Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Oct 10 1871 | 78 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Francis M. Fairbank
14. MOTHER'S MAIDEN NAME: Lottie Cerrigo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No
16. SOCIAL SECURITY NO:
17. INFORMANT: Herbert E. Fairbank ADDRESS: 2041 E. 32nd Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arterio-Sclerotic Heart Disease. | 7 yrs. |
| DUE TO (B) | Diabetes - Mellitus. | 5 yrs. |
| DUE TO (C) | - Fracture of Rt. Hip | 6 months |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

CERTIFICATION APPROVED
R.S. Fraben
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): accident
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2815 N. Calvert St. Balto
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): July 1 1949 p m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21F. HOW DID INJURY Ooccur? Fall in her bedroom on arising from her chair.

22. I hereby certify that I attended the deceased from Jan. 3, 1941, to Dec. 23, 1949, that I last saw the deceased alive on Dec. 23, 1949, and that death occurred at 6:30 P m., from the causes and on the date stated above.

23A. SIGNATURE: Earl L. Chambers M.D.
23B. ADDRESS: 4108 Liberty Hts.
23C. DATE SIGNED: 12/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 26 1949
24C. NAME OF CEMETERY OR CREMATORY: Green Mount Cem
24D. LOCATION (City, town, or county): Baltimore
24E. (State): Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 25 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ellis Amorman ADDRESS: 4510 Liberty Hts Ave

VS 150

186a

G81187 G81186 G81186

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81187 Registered No. 87

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Robert Bayard Kipe

2. DATE OF DEATH: 12-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: 0 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Union Bridge
D. STREET ADDRESS (If rural, give location): Route 9

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | S | 11-25-49 | | 1 0 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Hanover, Pa. | USA |

13. FATHER'S NAME: Hiram W. Kipe, Jr.

14. MOTHER'S MAIDEN NAME: Emily Francis Arnold

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | — |

17. INFORMANT: parents ADDRESS: Union Bridge, Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Intestinal obstruction | 2 days |
| DUE TO (B) | Imperforate anus | 1 month |
| DUE TO (C) | Post operative volvulus | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Severe dehydration | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-24 | Intestinal obstruction | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. I hereby certify that I attended the deceased from 12-24, 1949, to 12-25, 1949, that I last saw the deceased alive on 12-25, 1949, and that death occurred at 3:20 a.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Donald B. Bond, M.D. | Union Memorial Hosp | 12-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 12/27/49 | Mt. Pleasant Cem | Near Union Bridge Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington for Wm. Carroll, M.D. | Chas. Herring Hooper | 118 W. Mt. Royal Ave. 1579 |

CERTIFICATE CORRECTED 2-9-50 ✓

G31188 BALTIMORE CITY HEALTH DEPARTMENT G31188

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NICOLA CIGLIANO

2. DATE OF DEATH December 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GIULIANO Point Italian Ship Cigliano docked at Sparrows

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE ITALY
B COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Torre Del Greco

D STREET ADDRESS (If rural, give location) 25-5

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | Married | December 25/1895 | 54 | 11 | 29 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN 3RD CLASS ON SHIP

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Torre Del Greco Italy

12. CITIZEN OF WHAT COUNTRY? Italy

13. FATHER'S NAME Luigi Cigliano

14. MOTHER'S MAIDEN NAME ~~Cristina Guido~~ Lucia Visciano

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO

17. INFORMANT Orlando Cigliano ADDRESS 179 Union St. Brooklin N.Y.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE J. H. Fisher M.D.

23B CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED Dec. 24, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 26 1949 | Holy Redeemer Cem. | 4430 Belair Rd. Balt. Md. |

DATE RECEIVED BY LOCAL REGISTRAR DEC 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Frank Della Rocca ADDRESS 3225. High St. Balt. Md.

VS 151

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G81189

BIRTH NO. G81189

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 416

1. NAME OF DECEASED (Type or Print): Anthony J. Mateyka (Michael)
2. DATE OF DEATH: Dec. 22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore: 65 Yrs. 6 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-03
D. STREET ADDRESS (If rural, give location): 931 N. Collington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb 21, 1884 | 65 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Skilled Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Smeltering
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Mateyka
14. MOTHER'S MAIDEN NAME: Barbara Hakacek
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elizebeth Mateyka ADDRESS: 931 N Collington

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

| | | Interval between onset and death |
|---|---|---|
| (A) | Bronchopneumonia | 24 hours |
| DUE TO | | |
| (B) | Rheumatic C. V. D. | 10 yrs |
| DUE TO | | |
| (C) | Pulmonary Fibrosis (?) | 10 yrs |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1949 *to* Dec. 22 1949 *that I last saw the deceased alive on* Dec. 22 1949 *and that death occurred at* 6:30 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: J. Karl Grossman M. D.
23B. ADDRESS: 12 17 N Patterson Park Ave
23C. DATE SIGNED: 12/24/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-26-49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 26 1949
REGISTRAR'S SIGNATURE: Remington for Williams, M.D.
25. FUNERAL DIRECTOR: Frank Brach & Son
ADDRESS: 900 Gay, Chester

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G81190 BALTIMORE CITY HEALTH DEPARTMENT G81190

# CERTIFICATE OF DEATH

BIRTH NO. G81190 Registered No.

1. NAME OF DECEASED (Type or Print): Allen Burley
2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hosp.
c. Length of stay in Baltimore: 8 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1518 N. Monroe

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Colored | S | 1-18-1912 | 37 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Ocala Fla. | U.S. |

13. FATHER'S NAME: Allen Burley
14. MOTHER'S MAIDEN NAME: Malinda Lucomos

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | 215-18-3552 | Annie Jones | 432 N. Carey St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral thrombosis | 3 days |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 21, 1949, *to* Dec. 23, 1949, *that I last saw the deceased alive on* Dec. 23, 1949, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis N. Logan M.D. | Provident Hosp. | Dec. 23 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B. | 12-26-49 | | Ocala - Fla. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams M.D. | Samuel W. Sullivan Jr | 1011 N. Arlington Ave |

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G81191 BALTIMORE CITY HEALTH DEPARTMENT 253X G81191

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): FRANCIS W RIVERS
2. DATE OF DEATH: Dec. 23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2416 Pelham Avenue
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 2416 Pelham Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | MARRIED | Aug-6-1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist | | Baltimore - Md. | |

13. FATHER'S NAME: Augustus Rivers
14. MOTHER'S MAIDEN NAME: Margaret

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mrs. Eliz. Rivers ADDRESS: 2416 Pelham.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Occlusion | immediate Death |
| DUE TO (B) | myxedema | 1 year |
| DUE TO (C) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| no | none | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| none m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Dec 1st 1949, to Dec 23rd, 1949, that I last saw the deceased alive on Dec 20 1949. and that death occurred at 8 A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. A. Gordy M.D. | 5104 Harford Road | 12-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-26-49 | New Cathedral | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 26 1949 | Kensington Williams, M.D. | Leonard J. Ruck - 5305 Harford |

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G81192 BALTIMORE CITY HEALTH DEPARTMENT 450.0 G81192

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John F. Betz.

2. DATE OF DEATH: 12/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctors Hospital.

c. Length of stay in Baltimore - All his life. Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland. B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 613 North point Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | Widowed | 1869 - Jan. 14 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired. | Patto Rfg. Smelting | Baltimore. Md. | |

13. FATHER'S NAME: John Betz.

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Emma Fisher | 613 North point Rd. Balto |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestion of lungs. — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Acute Heart failure

DUE TO

(C) Arteria sclerosis -

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 19th 1949, to Dec 23 1949 *that I last saw the deceased alive on* 12-23-49 *and that death occurred at* 5:40 a.m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Louis J. Glass M. D. | 2724 N. Charles - | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/26/49 | Sacred Heart | Balto Md |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | [illegible] for Wm. Williams, M.D. | Leonard J. Luck | 5305 Harford |

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G81193 BALTIMORE CITY HEALTH DEPARTMENT G81193

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JACOB PARIS

2. DATE OF DEATH: 12-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3527 Oakmont Ave
C. Length of stay in Baltimore: 48 Yrs. ___ Mos. ___ Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-18
D. STREET ADDRESS (If rural, give location): 3527 Oakmont Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Grocer | Russia | |

13. FATHER'S NAME: Bernard

14. MOTHER'S MAIDEN NAME: Tobe

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Esther Paris | 3527 Oakmont Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertensive C.V. Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs plus

DUE TO

(B) Coronary Heart Disease — 3 yrs

DUE TO

(C) Diabetes Mellitus — 6 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 25 '49 *to* Dec. 25 1949, *that I last saw the deceased alive on* Dec 20, 1949, *and that death occurred at* 6:15 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Dr. M. S. Shulenberg M. D. | 2426 Eastern Ave | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-26-49 | Hebrew Herring Run | Dalto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams, M.D. | Jack Lewis Inc | 2100 Eastern Ave |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 44 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Ester Goverman 5-21279

2. DATE OF DEATH DEC 26 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 15-38
D. STREET ADDRESS (If rural, give location) 3713 Forest Park Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | 5-10-98 | 51 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Morris Feldman
14. MOTHER'S MAIDEN NAME Annie
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Atrophy | ? 2-3 mos |
| DUE TO (B) | Internal Hydrocephalus | ? 2-3 mos |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Hypertensive Arteriosclerotic heart disease | |

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-19- 1949 *to* 12-26- 1949, *that I last saw the deceased alive on* 12-26- 1949, *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE David E. Rogen M.D.
23B. ADDRESS Johns Hopkins Hospital
23C. DATE SIGNED 12-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-26-49
24C. NAME OF CEMETERY OR CREMATORY Hebrew Herring Law
24D. LOCATION (City, town, or county) (State) Balto Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 26 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Jack Lewis Inc
ADDRESS 2100 Eastern Ave

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BIRTH NO. 49-19450

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

571 Registered No.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Albert M. Kirchner | 2. DATE OF DEATH: 12/24/49 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission): A. STATE Md. B. COUNTY 21-02 |
| B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8 36 Warden to Belvd |
| c. Length of stay in Baltimore: 3 (Yrs. / Mos. / Days) | D. STREET ADDRESS (If rural, give location): 4125 Richardson St. (Orig) |

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Single | 9/12/49 | 3 mo. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Albert Kirchner | Mella Kight |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mrs. Albert Kight | 4125 Richardson St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Terminal pneumonia | 2 days |
| DUE TO (B) | Infectious diarrhea c | 6-7 days |
| DUE TO (C) | dehydration & acidosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/21, 1949 *to* 12/24, 1949 *that I last saw the deceased alive on* 12/24, 1949, *and that death occurred at* 1:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert A Levicks M.D. | St. Agnes Hospital | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/26/49 | Mt Olivet Cem. | 5930 Frederick Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams, M.D. | John J. Cowan & Son | 1119a Pulling St. |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 4201

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John D. Riley

2. DATE OF DEATH: Dec. 24-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 314 W. Cold Spring Ln

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Maryland B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 314 W. Cold Spring Lane

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-4

C. Length of stay in Baltimore: 64 yrs. (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 314 W. Cold Spring Lane

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | April 30-1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | Drill Press operator | Baltimore Md | U.S. |

13. FATHER'S NAME: George Riley

14. MOTHER'S MAIDEN NAME: Sophia Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or detailed service)

16. SOCIAL SECURITY NO.: 705-07-2364

17. INFORMANT: Mrs. Ada D. Riley ADDRESS: 304 W. Cold Spring Ln.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 1, 1948 *to* Dec 24, 1949 *that I last saw the deceased alive on* Dec 24, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward L. Harman M. D. | 4027 Falls Rd. | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 27-1949 | London Park Cem | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams, M.D. | Geo. L. Berger Jr. | 1512 Hollins St. Balto. Md |

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 5

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Lennah Stellar ? — 2. DATE OF DEATH: 12/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Years one, Months, Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: md. — B. COUNTY: Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Westminster
D. STREET ADDRESS (If rural, give location): Route 6

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W. | widowed | 12-18-1868 | 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | | Maryland | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Levi Lindsay | Lucinda Hooper |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | NONE | son G.L. Stellar | Westminster Rt 6 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Circulatory collapse | 24 hrs |
| DUE TO (B) | Low intestinal obstruction | 36 hrs |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | acute appendicitis ? volvulus mesenteric thrombosis ? | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | arteriosclerotic C.V.D. | years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| none | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/24, 1949, *to* 12/25, 1949, *that I last saw the deceased alive on* 12/25, 1949, *and that death occurred at* 9:20A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John R Hankins M.D. | University Hospital | 12/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-27-1949 | St. James | Carroll Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| [illegible] | Huntington Williams, M.D. | E. M. Waltz, | Winfield. Md. |

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G81198 BALTIMORE CITY HEALTH DEPARTMENT G81198

BIRTH NO. CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH W. BERNDT

2 DATE OF DEATH 12/23/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1511 E. 29th street

c. Length of stay in Baltimore Lifetime Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 1511 E. 29th street 907

5 SEX Female | 6 COLOR OR RACE white | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married

8 DATE OF BIRTH Mar. 2, 1887 | AGE (In years last birthday) 62 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper
10B KIND OF BUSINESS OR INDUSTRY Goucher College

11 BIRTHPLACE (State or foreign country) Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John J. Wight

14 MOTHER'S MAIDEN NAME Mary Kerr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)

16 SOCIAL SECURITY NO. 214-03-4851

17 INFORMANT Herbert Berndt ADDRESS 1511 E. 29th st.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death) | A Coronary Embolism | 15 months |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | B) Coronary Sclerosis | 2 years |
| DUE TO | | |
| | none | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY occur?

22. I hereby certify that I attended the deceased from 6-1-47 19 to 12-23rd 1949, that I last saw the deceased alive on 11/1/49 19, and that death occurred at 12 noon on the causes and on the date stated above.

23A. SIGNATURE F. H. Herrman M.D. | 23B ADDRESS 1710 E. 39 St | 23C DATE SIGNED 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B DATE 12/26/49 | 24C NAME OF CEMETERY OR CREMATORY Lorraine | 24D LOCATION (City, town, or county) (State) Balto. Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 26 1949 | REGISTRAR'S SIGNATURE Hunter for Williams, M.D. | 25 FUNERAL DIRECTOR Chas. S. Evans & Son, Inc. ADDRESS 944 118 N. Mt. Royal Ave.

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edwin Thrower

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Turners Station
D. STREET ADDRESS (If rural, give location): 219 Center St

5. SEX: male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 1-9-87
9. AGE (In years last birthday): 62 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Steel Mill
11. BIRTHPLACE (State or foreign country): No Carolina
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Edmond Shrower
14. MOTHER'S MAIDEN NAME: Ellen? Barrner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) ? Bronchopneumonia
DUE TO
(B) Pulmonary Fibrosis, Cause unknown

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Acquired hemolytic anemia, Cause unknown.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/28, 1949, *to* 12/22, 1949 *that I last saw the deceased alive on* 12/22, 1949, *and that death occurred at* 3 m., *from the causes and on the date stated above.*

23A. SIGNATURE: Robt C. Austrian M.D.
23B. ADDRESS: JOHNS HOPKINS HOSPITAL
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-26-49
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): A.A. Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Rayner Sanders ADDRESS: 1412 E. Preston St

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**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No. 416

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MABEL M. BROOKEY

2. DATE OF DEATH: 12/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-76
D. STREET ADDRESS (If rural, give location): 2216 Evelyn Ave #16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | MARRIED | 11/11/03 | 046 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| SALES LADY | HUTZLER Bros. | MD. | |

13. FATHER'S NAME: Abbie FOUCHE

14. MOTHER'S MAIDEN NAME: DAISY CUTSAIL.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No. | 217-10-6603 | Wm J Brookey 2216 Evelyn Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

(B) Rheumatic Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCoccur? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 12/9 1949 *to* 12/23 1949 *that I last saw the deceased alive on* 12/22 1949 *and that death occurred at* 7:50 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Blasco, M.D. | Maryland General Hosp. | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) / (State) |
|---|---|---|---|
| Burial | 12-27-49 | St Johns | Frederick / Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Evington Williams, M.D. | J Howard Strong | 3207 W. North Ave |

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G81201

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81201 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nannetta SEYTER

2. DATE OF DEATH: December 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 702 S. Clinton Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 702 S. Clinton Street 26 11

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 5, 1877
9. AGE (In years last birthday): 72 — If Under 1 Year: Months, Days — If Under 1 Day: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT — ADDRESS: Miss Charlotte A. Jones 4836 Keswick Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardiovascular disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/27/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): 7225 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949
REGISTRAR'S SIGNATURE: [illegible] for Williams, M.D.
25. FUNERAL DIRECTOR — ADDRESS: Clarence F. Hoffmann 1639 Broadway.

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Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MS—134383

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BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Johana Briscoe

2. DATE OF DEATH 12-23-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore — Yrs. life — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 3402 Toone St.

5. SEX Female

6. COLOR or RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH 12-23-1872

9. AGE (In years last birthday) 77 — If Under 1 Year: Months: Days — If Under 24 Hours: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Andrew Dasch (D)

14. MOTHER'S MAIDEN NAME Mary Dasch (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT ADDRESS Records--Baltimore City Hospitals 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary infarct, Rt. lung

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22- 1949 *to* 12-23- 1949, *that I last saw the deceased alive on* 12-23- 1949, *and that death occurred at* 7:30 A. M., *from the causes and on the date stated above.*

23A. SIGNATURE H. H. Hazen M. D.

23B. ADDRESS B.C.H.--4940 Eastern Ave.

23C. DATE SIGNED 12-23-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 12/26/49

24C. NAME OF CEMETERY OR CREMATORY Schwartz's Cemt.

24D. LOCATION (City, town, or county) (State) 5500 O'Donnell St. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 26 1949

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Clarence F. Hoffmann ADDRESS 1639 Broadway

VS Form 1949

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G81203

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

171 Registered No. G81203

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elsie D. Ledwa

2. DATE OF DEATH: 12/23/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3224 Toone St.
c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3224 Toone St. 76 0 6

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 11/8/1915 | 34 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At Home | | Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James M. Monroe | Elizabeth Crusse |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | John Ledwa (Husband) | 3224 Toone St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Cervix Uteri — INTERVAL BETWEEN ONSET AND DEATH: 18 mos ?

DUE TO

(B) Pelvic involvement gross

DUE TO

(C) Deep X-ray therapy & Radium

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July 20 1948 *to* Dec 23 1949, *that I last saw the deceased alive on* Dec 22 1949, *and that death occurred at* 8:20 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John W. V. Cliff M. D. | 5010 Greenleaf Road | 12-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/26/49 | Oak Lawn Cemt. | 7225 Eastern Ave. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Winston for Williams, M.D. | Clarence F. Hoffmann | 1639 Broadway |

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G81204 G81204

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Herbert Irvine
2. DATE OF DEATH: 12/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 8 14
D. STREET ADDRESS (If rural, give location): 1322 N. Sollington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year: Months / Days. If under 24 hours: Hours / Min.) |
|---|---|---|---|---|
| M | W | M | 12/21/95 | 54 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Pennsylvania | U.S. |

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) Hypertensive Cardiovascular Dis.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES 4 NO |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 12/25 1949 to 12/25 1949 that I last saw the deceased alive on 12/25 1949 and that death occurred at 9:45 p.m., from the cause and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Max Miller M.D. | Sinai Hospital | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town or County) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Moreland Mem | Taylor Ave. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 26 1949 | Curtis Williams, M.D. | Clarence F. Hoffmann 1639 Broadway |

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G81205

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81205 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jeanette S. Bower

2. DATE OF DEATH Dec. 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 1518 N. Broadway

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1518 N. Broadway

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | May 2, 1860 | 89. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Baltimore | U. S. |

13. FATHER'S NAME Ferdinand C. Strible

14. MOTHER'S MAIDEN NAME Mary Dalrymple

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Helen Bower | 1518 N. Broadway |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ac Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO

(B) Ch. Myocarditis

DUE TO

(C) Arterio sclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 1, 1949 *to* Dec 24, 1949 *that I last saw the deceased alive on* Dec 23, 1949. *and that death occurred at* 9:30 a. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J S Hardesty M. D. | 3805 Belair Rd | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 27, 1949 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams, M.D. | Rita Wiedefeld | 900 E. Biddle St |

VS 150 Dr Hardesty 3805 Belair Rd T 5643 937

G81206 ✓ G81296

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT FAGAN SR.,

2. DATE OF DEATH 12/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 1632 Hazel Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. COUNTY Curtis Bay
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 1632 Hazel Street, Balto, Md.
D STREET ADDRESS (If rural, give location) 1632 Hazel St. Curtis Bay, Md. I 5 05

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Jan 15,1887 | 62 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Steel Worker | U.S. Coast Guard | Baltimore, Md. | U.S. |

13. FATHER'S NAME: John Fagan

14 MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Barbara Fagan | 1632 Hazel Street |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

DUE TO

ANTECEDENT CAUSES

(B) Arteriosclerotic C.V. disease

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Cerebral fibrillation — 1½ yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10/17, 1948 *to* Dec 24, 1949, *that I last saw the deceased alive on* 11/26, 1949, *and that death occurred at* 10:15 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Sidney R. Gilbert M. D. | 4700 Pimlico Rd Ave. | 12/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/27/49 | Holy Cross | Annapolis Road. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 26 1949 | Huntington Williams, M.D. | 2501 E. Madison Street Schimunek Funeral Home Inc |

VS 150

931

G81207

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81207

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Amelia Wilmering,

2. DATE OF DEATH: Dec. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4724 Park Heights Ave.
c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D STREET ADDRESS (If rural, give location): 4724 Park Heights Ave., 2-16

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | single | May 23, 1878 | 71 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Seamstress | Dept. Store | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: Henry Wilmering,

14. MOTHER'S MAIDEN NAME: Anna (unknown)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | 212-03-7180 | Harry J. Wade, 4724 Park Heights Ave, |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | myocarditis | 1½ yrs. |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | Cataracts of both eyes. | 1½ yrs. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11/ , 19[illegible], *to* 12/ 24 , 1949, *that I last saw the deceased alive on* 12/ 6 , 1949, *and that death occurred at* 6 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. L. De Barbrin M. D. | 4723 Park Heights Ave., | 12/ /49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/27/49 | Holy Redeemer Cemetery | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 26 1949 | [illegible] | C. Vernon Lemmon, 4611 Park Heights Ave. |

VS 150

93E

G81208 **CERTIFICATE CORRECTED** 1-3-50 G81208

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 45

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Margaret L. Kinsey,

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE: Md. B. COUNTY:

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4646 Park Heights Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 27 16

c. Length of stay in Baltimore: 67 Yrs. [illegible] Days

D. STREET ADDRESS (If rural, give location): 4646 Park Heights Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| female | white | widow | Feb. 26, 1856 | 93 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Harford County, Md. | U.S.A. |

13. FATHER'S NAME: Benjamin Clotworthy ~~Kinsey~~ Cunningham

14. MOTHER'S MAIDEN NAME: Margaret E. Greenfield,

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Mary Joseph Kinsey | 4646 Park Hgt's |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5/16/47

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 16, 1947 *to* Dec 23, 1949, *that I last saw the deceased alive on* Dec 23, 1949, *and that death occurred at* 3.30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Allen O'Hubert M. D. | 7803 Park Heights Ave | Dec 23. 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/26/49 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Interington Williams, M.D. | C. Vernon Lemmon | 4611 Park Heights, |

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J.L. 1/4/50 G81209 ✓ 4rr.1 G81209?

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rose Edith Andrew

2. DATE OF DEATH: 12-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2734 Huntington Ave. 12-07

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 18 1877
9. AGE (In years last birthday): 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Carlton Harwaugh
14. MOTHER'S MAIDEN NAME: Amanda Wagman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: B.C.H. Records 4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial Failure
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO Arteriosclerotic cardiovascular disease,
(C) decompensation - senility

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
fracture left hip (7 yrs ago)

INTERVAL BETWEEN ONSET AND DEATH

(over)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-16-, 1949, *to* 12-26-, 1949 *that I last saw the deceased alive on* 12-26-1949, *and that death occurred at* 3.00AM *from the causes and on the date stated above.*

23A. SIGNATURE: G. S. Cogen M. D.
23B. ADDRESS: B.C.H. 4940 Eastern Ave.
23C. DATE SIGNED: 12-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 29, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. View
24D. LOCATION (City, town, or county) (State): Emmitsburg, Maryland ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Evelyn Williams
25. FUNERAL DIRECTOR: S. L. Allison Emmitsburg, Md.

DEC 29 1949

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81210 G81210

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MORRIS A JENNINGS

2. DATE OF DEATH: 12/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 544 E. CLEMENT ST.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 544 E. Clement St 24-0 W

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Div.
8. DATE OF BIRTH: JUNE 10, 1877
9. AGE (In years last birthday): 72
If under 1 Year: Months / Days
If under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM H. JENNINGS
14. MOTHER'S MAIDEN NAME: SUSAN HARTLESS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs FLORA A. BROWN ADDRESS: 2624 W. LAFAYETTE Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
ANTECEDENT CAUSES
(B) Arteriosclerosis — 2 yr.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1, 1949, *to* Dec. 24, 1949, *that I last saw the deceased alive on* Dec 23, 1949 *and that death occurred at* 11:50 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 707 Fort Ave.
23C. DATE SIGNED: 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE: 12/27/49
24C. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE Cem
24D. LOCATION (City, town, or county) (State): WASHINGTON Blvd. Md

DATE RECEIVED BY LOCAL REGISTRAR: 1949
REGISTRAR'S SIGNATURE: [signature] for Williams, M.D.
25. FUNERAL DIRECTOR: JOHN F. DENNY INC
ADDRESS: 715 LIGHT St.

VS 150

94a

G81211

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

G81211 Registered No.

STATE NO

1. NAME OF DECEASED (Type or Print): Arthur Jerome Stewart
2. DATE OF DEATH: Dec. 24, 1949
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Maryland B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-C
3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1708 McCulloh St.
D. STREET ADDRESS (If rural, give location): 1708 McCulloh St.
c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | Colored | Single | June 5 1943 | 6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | — | Baltimore, Md. | U. S. A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ernest Stewart | Sola Shelton |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Ernest Stewart | 1708 McCulloh St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Broncho-pneumonia | 3 days. |
| DUE TO (B) | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Bronchitis Acute | 3 days |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-23, 1949 *to* 12-24-, 1949 *that I last saw the deceased alive on* 12-24, 1949, *and that death occurred at* 12:30 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Geo. A. Fuld Jr. M.D. | 1723 Druid Hill Ave | 12-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 26, 1949 | Family Lot | Blackstone, Va. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 VS 150 | Hunter for Williams, M.D. | Holland Funeral Home | 1631 Druid Hill Ave. |

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G81212

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81212 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Pauline Rideout
2. DATE OF DEATH: Dec. 24, 1949
3. PLACE OF DEATH: Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
   a. STATE: Maryland
   b. COUNTY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 7-05
   d. STREET ADDRESS (If rural, give location): 809 Sutton St. (Shelter)
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1408 Brunt St.
   c. Length of stay in Baltimore: Yrs. Mos. Days
6. SEX: Female
7. COLOR OR RACE: Colored
8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
9. DATE OF BIRTH: Jan. 22, 1920
10. AGE (In years last birthday): 29 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: Odd Jobs
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Rideout
14. MOTHER'S MAIDEN NAME: Annie Marie Reed
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Sterling K. Rideout ADDRESS 809 Sutton St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Lymphopathia Venerea — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(b) Stricture, Urogenital, 1 year

DUE TO

(c)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/23, 1949 *to* 12/24, 1949 *that I last saw the deceased alive on* 12/23, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: M. Jackson, M.D.
23b. ADDRESS: 600 Washington
23c. DATE SIGNED: 12/26/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 26, 1949
24c. NAME OF CEMETERY OR CREMATORY: Arbutus Mem. Pk.
24d. LOCATION (City, town, or county) (State): Baltimore Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 26 1949
REGISTRAR'S SIGNATURE: Courtney for Williams, M.D.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave

VS 150

93E

Correct Age if especially important. If spinster, please write the name of maiden family and registry.

G81213 ✓ G81213

BIRTH NO G81213

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

177 Registered No.

1. NAME OF DECEASED (Type or Print): Reverend Matthias Williams

2. DATE OF DEATH: Dec 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 515 N. Carrollton Ave.
c. Length of stay in Baltimore: 75 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 515 N. Carrollton Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | married | April 15, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Minister | Rural | Howard Co. Md. | U.S.A. |

13. FATHER'S NAME: Moses Williams

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs Bertha Williams ADDRESS: 515 N.Carrollton Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Prostate
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: about 6 mos.

19A. DATE OF OPERATION: None
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* July 10, 1941 *to* Dec 23, 1949 *that I last saw the deceased alive on* Dec 23, 1949, *and that death occurred at* 4:20 p m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: 515 Druid Hill Ave Md
23C. DATE SIGNED: Dec 24 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 27 1949
24C. NAME OF CEMETERY OR CREMATORY: West Liberty Cemetery
24D. LOCATION (City, town, or County) (State): Howard Co. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 26 1949
REGISTRAR'S SIGNATURE: [signature], M.D.
25A. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

51 B

G81214

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81214 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Bergler

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. Md

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 108 S. Castle St.

c. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 108 S. Castle St. 2-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | SINGLE | AUG. 13 1863 | 86 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AT HOME | AT HOME | BALTO. MD | U.S.A. |

13. FATHER'S NAME: ANDREW BERGLER

14. MOTHER'S MAIDEN NAME: BARBARA ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | 104 M. RITTER | 110 S. CASTLE ST |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Heart Disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Dec. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC 27-49 | HOLY REDEEMER | BELAIR RD BALTO MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams M.D. | DIPPEL BROS. | 1806 E. LOMBARD ST |

VS-11

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# CERTIFICATE CORRECTED 12-27-49

BS--134423 G81215 G81215

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): Eva Kobleder

2. DATE OF DEATH: 12-24-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): Rt. 13 Box 347 Cedar Beach Zone 21

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months Days | If under 24 hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Oct. 8, ~~1874~~ 1876 | 75 ~~73~~ | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AT HOME | AT HOME | Maryland | U.S.A. |

13. FATHER'S NAME: George Itzel

14. MOTHER'S MAIDEN NAME: Elizabeth Hahn

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT'S ADDRESS |
|---|---|---|---|
| No | — | — | Baltimore City Hospitals Records--4940 Eastern Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardiac Insufficiency

DUE TO

(B) Hypertensive Heart Disease

DUE TO

(C)

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-24- , 1949, *to* 12-24- , 1949, *that I last saw the deceased alive on* 12-24- , 1949, *and that death occurred at* 12:00P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| J. L. Rogers M.D. | B.C.H.--4940 Eastern Ave. | 12-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC-27-49 | HOLY REDEEMER | BELAIR RD BALTO MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 26 1949 | Huntington Williams, M.D. | DIPPEL BROS | 1806 ELDERSLOE BARD ST |

VS 150

93D

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81216

Teacher

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

401.3

G81216 Registered No.

STATE NO.

1. NAME OF DECEASED (Type or Print) Mormon Teacher

2. DATE OF DEATH 12-26-49.

3. PLACE OF DEATH Baltimore City, Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Univ. Hosp

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MD
b. COUNTY 20-01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 245 N. Payson St

5. SEX M
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH 1919
9. AGE (In years last birthday) 30
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Norfolk Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Edward J Teacher
14. MOTHER'S MAIDEN NAME Mary Schools
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Aunt Friend Home Wilson N. C

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure
DUE TO
(B) Rheumatic C. V. disease
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-24 19 49, *to* 12-26, 19 .., *that I last saw the deceased alive on* 12-26, 19 .., *and that death occurred at* 1009 m., *from the causes and on the date stated above.*

23A. SIGNATURE Robert Holm M. D.
23B ADDRESS Univ. Hosp
23C DATE SIGNED 12-28

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/29/49
24C. NAME OF CEMETERY OR CREMATORY Maplewood
24D. LOCATION (City, town, or county) Wilson N C (State)

DATE RECEIVED BY LOCAL REGISTRAR DEC 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Wilson Co Dan 129 W Nash St
ADDRESS

VS 150

93c

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81217

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81217

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY SISLER

2. DATE OF DEATH Dec. 23, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4413 Kavon Ave.

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4413 Kavon Ave.

3C. Length of stay in Baltimore — Yrs. 26 Mos. 07 Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | Feb. 14, 1864 | 85 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At. Home | Germany | |

13. FATHER'S NAME: Joseph Schreiber

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Charles A. Sisler | 4413 Kavon Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Ch. Myocarditis

DUE TO

(C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 21, 1949 *to* Dec 23, 1949, *that I last saw the deceased alive on* Dec 22, 1949 *and that death occurred at* 9 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jos Standing M. D. | 3805 Pelair Rd | 12/24/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/27/49 | Oak Lawn | Baltimore Co., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | William Cook, Inc., | 1217 St. Paul St. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

937

C81218

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C81218

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maude L. Tucholka

2. DATE OF DEATH: Dec. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — 5115 Eugene Avenue
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 5115 Eugene Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Nov. 23, 1905 | 44 | 1 / 1 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Texas | |

13. FATHER'S NAME: M. Lacy Johnston

14. MOTHER'S MAIDEN NAME: Maude Browne

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | None | Gerard M. Tucholka | 5115 Eugene Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☑, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

23A. SIGNATURE: Earl L Royer M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: 12-25-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Loreland Memorial Gardens | Baltimore Co Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR'S SIGNATURE: Washington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: William Cook, Inc. — 1217 St. Paul Street

VS 151

93D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C81219

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

59

C81219
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. LeRoy Spilser (Spiker)

2. DATE OF DEATH 12/24/49

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore, #12
D. STREET ADDRESS (If rural, give location) 211 Melrose Ave.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hospital

c. Length of stay in Baltimore: Yrs. Life Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| M | W | M | Oct. 1, 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Policeman | Balto. City | Maryland | USA. |

13. FATHER'S NAME: Mr. Edward Spilser

14. MOTHER'S MAIDEN NAME: Catherine Frohlicks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Viola Spilser, ADDRESS Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Glomerulo nephritis — many yrs.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/22, 1949 *to* 12/24, 1949 *that I last saw the deceased alive on* 12/24, 1949 *and that death occurred at* 7 P. m. *from the causes and on the date stated above.*

23A. SIGNATURE Ronald L. Slaton M. D.
23B. ADDRESS Church Home Hosp.
23C. DATE SIGNED Dec. 25/1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/29/49
24C. NAME OF CEMETERY OR CREMATORY Cedar Hill
24D. LOCATION (City, Town, or County) (State) Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 27 19[illegible]
REGISTRAR'S SIGNATURE Hunter for Williams, M.D.
25. FUNERAL DIRECTOR Wilson & Son ADDRESS 1218 Hollins St

1218

VS 150

Age is especially important. Physicians: please write the causes of death clearly and legibly.

G81220

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81220 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank D. Moulton
2. DATE OF DEATH: Dec. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Essex
D. STREET ADDRESS (If rural, give location): 319 Oldale Rd NE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Widow | 3-12-75 | 74 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanic | Unknown | Rehoboth Mass | |

13. FATHER'S NAME: James Moulton
14. MOTHER'S MAIDEN NAME: Leonora Chase

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardiac failure | 2 mos |
| DUE TO (B) | Coronary arteriosclerosis | 9 years |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | [illegible] | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/9 1949 *to* 12/26, 1949 *that I last saw the deceased alive on* 12/26, 1949, *and that death occurred at* 8:20 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph D.B. King M.D. | | 12-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Rehoboth Village | Rehoboth Mass |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Fulton & Co Inc | 1217 St Paul St |

VS, 150

94a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81221

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

96 G81221

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Thomas J.Ward

2. DATE OF DEATH Dec.25th.,1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 815 E.22nd.Street

c. Length of stay in Baltimore 50 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY City

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 815 E.22nd.,Street 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year Months Days | If under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | Oct. 1889 | 60 | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Plumber | Plumbing | Ireland | U.S.A |

13. FATHER'S NAME John Ward

14. MOTHER'S MAIDEN NAME Kathleen Callan

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| NO | | |

17. INFORMANT ADDRESS Mr.John G.Ward- 815 E.22nd.,Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of right [illegible] jaw

DUE TO

ANTECEDENT CAUSES

(B) with secondary lungs etc.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 7-8 yrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 4 Dec, 1949 *to* 25 Dec, 1949 *that I last saw the deceased alive on* 25 Dec, 1949, *and that death occurred at* 11:30 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Silverfels M.D. | 714 E. Preston St | 26 Dec.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/49 | New Cathedral Cemetery | Edmondson Ave.Balto:Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Justin for Williams, M.D. | George J.Ruth,Inc. | 1735 Harford Avenue |

VS 150

45D

Correct age is especially important. Physician: please write the causes of death clearly and legibly.

G81222 ✓ G81222

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 190

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Joseph Champness

2. DATE OF DEATH: December 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2135 Sinclair Lane

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SEPARATED
8. DATE OF BIRTH: MAY 17, 1898
9. AGE (In years last birthday): 51
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Counterman
10B. KIND OF BUSINESS OR INDUSTRY: N. E. Supplies
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ROBERT H. CHAMPNESS
14. MOTHER'S MAIDEN NAME: ANNA W. GOEB ✓

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO:
17. INFORMANT: MISS MYRTLE CHAMPNESS ADDRESS: 2135 SINCLAIR LANE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar pneumonia, left
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Cardiac decompensation

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 23, 1949 *to* Dec. 24, 1949 *that I last saw the deceased alive on* Dec. 24, 1949, *and that death occurred at* 5:30a *m., from the causes and on the date stated above.*

23A. SIGNATURE: Thaddeus Siwinski M. D.
23B. ADDRESS: 1400 N. Caroline St.
23C. DATE SIGNED: Dec. 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-27-49
24C. NAME OF CEMETERY OR CREMATORY: HOLY REDEEMER CEM.
24D. LOCATION (City, town, or county) (State): 4430 BELAIR RD. BALTO. MD.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Charles S. Zeiler ADDRESS: 901 S. Conkling St.

VS 150.m

108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81223

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81223
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ralph R. Miller
2. DATE OF DEATH: 12/25/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Doctor's Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1931 Wilkens ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M. | W. | married | July 27, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Fireman | Balto. City Fire Dept | Balto. Md | |

13. FATHER'S NAME: John Miller
14. MOTHER'S MAIDEN NAME: Margaret ——

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Mrs. Helen Miller, 1931 Wilkens ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO
(B) Acute Coronal (Cardiac) Occlusion — 2 wks
DUE TO
(C) myocardial failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/9/, 19[illegible], *to* 12/25, 1949, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 12[illegible] m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | 2730 N Charles St | 12/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Western | Edmondson Ave. Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | Harry A. Kirkpatrick | 4101 Edmondson ave. |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

107

G81224

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81224 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mamie Weilbrenner (Mrs. Adam)

2. DATE OF DEATH: 12-25-49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2035 Cliftwood ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hosp.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Fe | White | Married | Sept. 23 1890 | 59 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: August Tegeler

14. MOTHER'S MAIDEN NAME: Magdalena Heth

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mr. Adam Weilbrenner |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12-6-49 | No signs of brain tumor | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about house, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| accident & Home | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Dec. 2 49 2P.m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Spontaneous hemorrhage |

22. *I hereby certify that I attended the deceased from* Dec. 2, 1949, *to* Dec. 25, 1949, *that I last saw the deceased alive on* Dec. 25, 1949, *and that death occurred at* 8:45P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Alan Douglass M.D. | Union memorial Hosp. | 12-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/29/49 | Parkwood Mausoleum | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Lasagna Funeral Home | 7401 Belair Rd. |

VS 150

83a

G81225

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

50.0

G81225 Registered No.

STATE NO.

1. NAME OF DECEASED (Type or Print) ANNA ELIZABETH NELCK

2. DATE OF DEATH Dec. 26 '49

3. PLACE OF DEATH
a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2639 WILKENS AVE

c. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 2639 WILKENS AVE

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | WIDOWED | SEPT 20 1871 | 78 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | GERMANY | |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT DAUGHTER ADDRESS |
|---|---|---|
| | | MRS ALICE NELCK - 2639 WILKENS |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov. 27, 1949, *to* Dec. 25, 1949, *that I last saw the deceased alive on* Dec. 25, 1949, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert H. Katz M. D. | 2675 Wilkens Ave. | Dec. 27/1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC. 29 '49 | NEW CATHEDRAL | BALTO. MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Henry A Wiltse | 4101 Edmondson |

VS 150

97

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81226

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81226

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Watmough, Mr. William Nicklin | 2. DATE OF DEATH 12-26-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home & Hosp.
c. Length of stay in Baltimore 70 Yrs. Mths. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 6 East Read Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | April 18, 1872 | 77 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Virginia | U. S. A. |

13. FATHER'S NAME: William Watmough
14. MOTHER'S MAIDEN NAME: Unknown / Elizabeth Sands
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-03-2266
17. INFORMANT: Mr. Wm. N. Watmough Jr. ADDRESS: Brooklandville Md.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 week

DUE TO

(B) Arteriosclerotic cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH: many yrs.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 21st, 1949, to Dec. 26th, 1949, *that I last saw the deceased alive on* Dec. 25th, 1949, *and that death occurred at* 6:55 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ronald L. Liston M. D. | Church Home & Hosp. | 12-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | Dec 27 1949 | Green Mount | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams M.D. | Henry N. Jenkins & Sons Co. | 4925 York Rd. |

VS 150

92D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81227

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. G81227

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Anna Marie Krickbaum

2. DATE OF DEATH: 12/26/49

3. PLACE OF DEATH
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Elkridge
D. STREET ADDRESS (If rural, give location): 1118 Railroad Ave.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: April 18 1875
9. AGE (In years last birthday): 74
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Peter Boer
14. MOTHER'S MAIDEN NAME: Margaret Bueltmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Henry Krickbaum ADDRESS: 1118 Railroad Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I (a) | Congestive heart failure | |
| DUE TO (b) | Arteriosclerotic Hypertension | |
| DUE TO (c) | CVA | |
| II | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Chronic nephritis | |

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT SUICIDE HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/24 1949 *to* 12/26 1949 *that I last saw the deceased alive on* 12/26 1949 *and that death occurred at* 8 40 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Herbert J. Krickbaum M.D.
23B. ADDRESS: St. Agnes Hospital
23C. DATE SIGNED: 12/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 29/49
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Mem.
24D. LOCATION (City, town, or county) (State): Howard Co Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Henry W. Jenkins Sons
ADDRESS: 4905 York Rd

121a

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

81228 BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

433 0 Registered No. 81228

1. NAME OF DECEASED (Type or Print): GUY HARRISON REESE
2. DATE OF DEATH: DEC. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 210 E. BELVEDERE AVE
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): BALTO 27 ✓
D. STREET ADDRESS (If rural, give location): 210 E. BELVEDERE AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | MAY 17, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| BANKER | | MD. | U.S. |

13. FATHER'S NAME: PERCY MEREDITH REESE
14. MOTHER'S MAIDEN NAME: McCORMICK

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | MRS. B. E. REESE | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Stokes Adams Disease
DUE TO
(B) Myocarditis - Heart Block
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1949 *to* Dec, 1949, *that I last saw the deceased alive on* Dec 24, 1949 *and that death occurred at* 11 30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter A Baetjer | 1101 St Paul St | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-27-49 | GREENMOUNT | BALTO. MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | H. W. JENKINS & SONS CO | 4905 YORK RD |

VS 150

95a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81229

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81229 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN FRANCIS MAGUIRE

2. DATE OF DEATH: Dec. 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1618 Cliftview Avenue
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: Maryland
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1318 Cliftview Avenue

5. SEX: Male M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower
8. DATE OF BIRTH: Dec. 23, 1867
9. AGE (In years last birthday): 81 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baltimore Fire Dep't
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Maguire
14. MOTHER'S MAIDEN NAME: Barbara ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Wm. A. Maguire 1618 Cliftview Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic C-V disease | 10 yrs. |
| DUE TO (B) | Chronic nephritis | 2 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | General arteriosclerosis; R-heumatoid Arthritis | 2 yrs. 35 yrs. |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1945 *to* Dec 24, 1949 *that I last saw the deceased alive on* Dec 24, 1949 *and that death occurred at* 3 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Kenneth H. Krauser M.D. M.D.
23B. ADDRESS: 1428 Kingsway Rd.
23C. DATE SIGNED: 12-26-49

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 12/27/49
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC.
ADDRESS: BALTIMORE - 13, Md.

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C81230

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C81230

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANDREW JACKSON

2. DATE OF DEATH: December 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 314 Forrest Street
c. Length of stay in Baltimore: 25 yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 314 Forrest Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | April 22nd 1899 | 50 yrs | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Md. | |

13. FATHER'S NAME: Charles Jackson
14. MOTHER'S MAIDEN NAME: Susan Gross

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Gertrude Hartley 314 Forrest St |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral embolism due to auricular fibrillation with mural thrombosis | |
| ANTECEDENT CAUSES | DUE TO | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Other Conditions: Strangulated ileum, complicating ruptured appendix | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| C. L. Tulenko M.D. | | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | DEC 27 1949 | Mt Calvary | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Twittington Williams M.D. | Byron & Francis H. Wright | 1217 Druid Hill Ave |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FL.
G81231

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81231

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ernest Bradford

2. DATE OF DEATH: 12-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 8 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1024 Central Ave. Z2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | Negro | Single | Aug 27- 1930 | 19 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | S.C. | |

13. FATHER'S NAME: Ernest Bradford

14. MOTHER'S MAIDEN NAME: Hannah Bilmore

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | B.C.H. Records 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | (INTERVAL BETWEEN ONSET AND DEATH) |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary Tuberculosis | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | | |
| DUE TO | | |
| (C) | | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12- 2- , 1947, *to* 12- 26- , 19 49 *that I last saw the deceased alive on* 12- 26 , 1949 , *and that death occurred at* 3.50 AM., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. K. Rogers M.D. | B.C.H? 4940 Eastern Ave. | 12-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12-30-49 | Mt. Calvary | A. A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 27 1949 | Tuttington Williams M.D. | Samuel W. Sullivan Jr 13 E 1011 N. Arlington Ave |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MS—134340 CERTIFICATE CORRECTED 1-9-50 ✓ ✓ G81232

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

81232 BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print) William Bridgeforth Bridgeford

2. DATE OF DEATH 12-21-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE ? B. COUNTY ?

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ?

c. Length of stay in Baltimore ? Yrs. Mos. Days

d. STREET ADDRESS (If rural, give location) 1119 Calhoum St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | Married | [illegible] | 72? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| ? | | ? Virginia | |

13. FATHER'S NAME ? ?

14. MOTHER'S MAIDEN NAME ? ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-20- *, 19*49*, to* 12-21- *, 19*49*, that I last saw the deceased alive on* 12-21- *, 19*49*, and that death occurred at* 8:30 PM *, from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | B.C.H.--4940 Eastern Ave. | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-27-49 | Mt Auburn | Cety. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | [illegible] | A. Halstead | 918-13 E Lluid Hill ave. |

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MS.- 134294

81233

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

6 92 4

Registered No. G81233

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print) Emnanuel Russell | 2. DATE OF DEATH 12- 24- 49 |
| 3. PLACE OF DEATH: Baltimore City, Maryland | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY |
| 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave. | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore |
| c. Length of stay in Baltimore 6 Yrs. (Yrs. Mos. Days) | D. STREET ADDRESS (If rural, give location) 1425 N. Charles ST. 11-02 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct, 22 1878 | 71 ? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Laborer | Empire Construction Co | Pennsylvania | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Russell | Christine |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | B.C.H. Records 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Gastric Dilatation | |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Cellulitis Right Lower leg | |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Simple Obesity | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12- 17- 1949 *to* 12- 24- 1949 *that I last saw the deceased alive on* 12- 24- 1949 *and that death occurred at* 6:25 AM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | B.C.H. 4940 Eastern Ave. | 12- 26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/49 | Mt Carmel | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Kenneth for Williams, M.D. | Wilhelm Corkran | 1214 Ford St |

VS 150

152

G81234

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81234

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis WEINBERG

2. DATE OF DEATH: 12-25-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6701 Park Heights Ave

c. Length of stay in Baltimore: 64 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-20
D. STREET ADDRESS (If rural, give location): 6701 Park Heights Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | married | | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | Clothier | England | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Myer Solomon | Sarah |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Rose Weinberg | Arlington Park Apts |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary thrombosis | 2 days |
| DUE TO (B) | arteriosclerotic heart disease | 18 yrs? |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | arteriosclerosis of coronary arteries | 10 yrs? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Pulmonary Edema | 2 hrs. |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 23, 1949 *to* Dec 25, 1949 *that I last saw the deceased alive on* Dec 25, 1949 *and that death occurred at* 4½ p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Cohen M. D. | 5901 Park Heights Ave | 12/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-27-49 | Hebrew Friendship | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Jack Levin Inc | 2100 Eutaw Place |

VS 150

92

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81235

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

16 ✓ G81235 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HERMAN (HYMAN) GLAZER

2. DATE OF DEATH: 12-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1809 East Pratt St

C. Length of stay in Baltimore: 56 Yrs. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1809 East Pratt St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Widowed | ? | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Russia | |

13. FATHER'S NAME: Yankel Mayer Glazer

14. MOTHER'S MAIDEN NAME: Rose

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Rebecca Glazer - wife | 1809 E Pratt St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Primary Bronchogenic Carcinoma
DUE TO
(B) Lung with Metastases
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Coronary Artery Disease - Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: (A) 8 mos

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 19, 1949 *to* Dec. 26, 19 49, *that I last saw the deceased alive on* Dec 26 19 49 *and that death occurred at* 2:55 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Max Stamps M.D.
23B. ADDRESS: 1809 E. Pratt St
23C. DATE SIGNED: 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-28-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (City, town, or county) (State): Balto Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jack Sears Inc
ADDRESS: 2100 Eutaw Pl

VS 150

47c

G81236

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

491 G81236 Registered No.

1. NAME OF DECEASED (Type or Print): Carrie E. Harris

2. DATE OF DEATH: 12/22/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1425 Monument Street

c. Length of stay in Baltimore: 22 Yrs. rs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. City
D. STREET ADDRESS (If rural, give location): 1425 Monument Street

5. SEX: Female
6. COLOR OR RACE: Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9/19/1898
9. AGE (In years last birthday): 51 — If under 1 year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unkown
14. MOTHER'S MAIDEN NAME: Nukown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elder Thomas Harris
ADDRESS: 1425 Monument

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
Broncho Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 days

DUE TO
Colds and Nevritis — Indefinite

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/14 49 *to* 12/22 49, *that I last saw the deceased alive on* 12/21 1949 *and that death occurred at* 11 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE: Jas. R. Blake M. D.
23B. ADDRESS: 1603 N. Carolina
23C. DATE SIGNED: 12/26/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/27/1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Nat. Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elroy O. Wilson
ADDRESS: 1000 Brantly Ave.

VS 150

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correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81237

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81237

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mabel Vaquehart Credit

2. DATE OF DEATH 12/24/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore

D. STREET ADDRESS (If rural, give location) 804 W Lanvale st.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) President Hospital

c. Length of stay in Baltimore 24 Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Fe | N | Widowed | 10/11/00 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Teacher | Education | Virginia | U.S.A. |

13. FATHER'S NAME: John Vaquehart

14. MOTHER'S MAIDEN NAME: Alice Cross

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Robert Mitchell, Jr. | 804 W. Lanvale |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Uremia | 4 days. |
| DUE TO (B) | Hypertensive C-V Renal Dis. | 10-15 yrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 8/21 1949 *to* 12/24 1949, *that I last saw the deceased alive on* 12/23 1949, *and that death occurred at* 1:10 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Preston Grant M. D. | 681 N. Carrollton | 12/24/49 |

| 24. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12-27-49 | Balto - National | Balto City |

| DATE RECEIVED BY REGR. | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Kathryn for Williams, M.D. | William A. Cockeran | 916 Penna Ave |

VS 150

131a

G81238

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81238 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harriett (Hattie) V. Kelley

2. DATE OF DEATH: 12/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3109 Oakley Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md
b. COUNTY: Balto
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 3109 Oakley Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | May 10, 1891 | 58 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | Baltimore | U.S.A. |

13. FATHER'S NAME: John Saddler

14. MOTHER'S MAIDEN NAME: Florence Unknown

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mr. A. Clark Kelley | 3109 Oakley Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: Dec 5. 1949
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 5, 1949 *to* Dec 24, 1949 *that I last saw the deceased alive on* Dec 24, 1949, *and that death occurred at* 9.45 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm D Bubert M.D. | 4803 Park Heights Ave | Dec 26. 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | December 27/49 | Druid Ridge | Pikesville, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Long Byers | 5005 Park Heights Ave. |

VS 150

94a

Please write every item of information called for, and write correct age in years, months, days, hours or minutes. Physicians: please write the cause of death clearly and legibly.

681239

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 681239

1. NAME OF DECEASED (Type or Print) Pauline Henry. 21785-4

2. DATE OF DEATH DEC 24 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) OHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 807 Vine, St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | Colored | married | 5-15-43 | 5-6 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto Md | |

13. FATHER'S NAME Joseph Fisher

14. MOTHER'S MAIDEN NAME Annie Gaffer

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | OHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriolo nephrosclerosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) H-Hypertensive Cerebrovascular Dis — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-2- 1949 *to* 12-24- 1949 *that I last saw the deceased alive on* 12-24 1949, *and that death occurred at* 2 40 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Arons M.D. | Johns Hopkins Hospital | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/49 | Mt Auburn Ct | Balto City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Municia for Williams, M.D. | D. L. Brown & Son | 108 W. Montgomery St |

VS 150

121a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C81240

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E916.0

Registered No. C81240

1. NAME OF DECEASED (Type or Print) CHARLES A. BELL, JR.

2. DATE OF DEATH December 25, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY Queen Anne
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Centreville Md
D STREET ADDRESS (If rural, give location)

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Baltimore General Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | | July 21, 1926 | 23 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farming | Same | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles A. Bell, Sr | Anna Green |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | P | Stella M. Bell | 2232 Saratoga St |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

I (A) Cranial cerebal injuries — DUE TO

II (B) — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(C) —

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | friend's home | 2232 N. Saratoga Street |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 25, 1949 4.30 P.M. | | Explosion of a homemade bomb |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Dec. 26, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 12/28/49 | Lorraine Park Cem | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | Chas P Towell | 2427 Edmondson Ave |

VS 151

195E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81241

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81241

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances Lawson

2. DATE OF DEATH: Dec 25 - 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 611 W. Lee St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): —

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Beeto. B. COUNTY: 611 W. Lee St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Beeto
D. STREET ADDRESS (If rural, give location): 611 W Lee St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Colored | Widow | 11-23-1884 | 65 | 1 | 2 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at Home | none | Beeto | U.S.A |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Jennie Sorrell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Jeannette Lawson — ADDRESS: 611 W. Lee St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency
DUE TO
(B) Coronary occlusion
DUE TO
(C) Hypertensive Cardiovascular Renal disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 4, 1949, to Dec 25, 1949 that I last saw the deceased alive on Dec 7, 1949 and that death occurred at 9:00 A.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Sherfok M.D M. D | 601 N. Monroe St | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 30 49 | not known | Balto |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR: Hamilton for Baltimore, Md

25. FUNERAL DIRECTOR: James Sadays — ADDRESS: 6587 Gilmore

VS 150

131a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81242

BIRTH NO. 48-04651

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916.0

Registered No. G81242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Magnola Parks — Negro

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1720 W. Lanvale St. 16 0 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Single | March 2, 1948 | 1 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Theodore Parks, Sr.

14. MOTHER'S MAIDEN NAME: Cleola Dixon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carbon monoxide asphyxia | |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Second & Third Degree Burns, 40 % of Body | |
| DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | (C) | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1720 W. Lanvale St. 16/3 |
|---|---|---|
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Dec. 23, 1949 10 A.m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCoccur? Conflagration |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: R S Fraser M.D.

23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐

23C. DATE SIGNED: Dec. 24, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 27-49 | Mt Auburn | Balto |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: James A Sayos ADDRESS: 638 N Gilmor

VS 151

180

G81243 4-56 333

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916 D G81243 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theodore Parks, Jr. — 2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH:
a. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): FRANKLIN SQUARE HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1720 W. Lanvale St. 16 3

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | Sept. 10, 1946 | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | |

13. FATHER'S NAME: Theodore Parks, Sr.
14. MOTHER'S MAIDEN NAME: Cleola Dixon

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Second and Third Degree Burns of | |
| | DUE TO 50% of body | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) DUE TO | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 1720 W. Lanvale St. 16/3 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Dec. 23, 1949 10 A.M. | | Conflagration |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | Dec. 24, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 27-1949 | Auburn | Balto |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | James A. Dayes 1284 N. Fulton Ave |

VS 151

180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81244

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

177 Registered No. G81244

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Andrew A. Johnson

2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 124 Callender St.

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 18-03
D. STREET ADDRESS (If rural, give location): 124 Callender St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 1 Day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | white | married | 5/7/1878 | 71 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pipe fitter | Koppers Co. | Baltimore Md. | U.S.A |

13. FATHER'S NAME: Andrew Johnson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Matilda A. Erbe ADDRESS: 4 Callender St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

DUE TO

(B) Hypertensive Cardio Vascular disease — years.

DUE TO

(C) Carcinoma of prostate — unknown.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Malnutrition

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 8, 1948, *to* Dec. 26, 1949, *that I last saw the deceased alive on* Dec. 25, 1949, *and that death occurred at* 445 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles Tumminello M. D. | 910 W. Lombard St | Dec. 27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Mt Olivet Cem. | 2930 Frederick Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Thurlington Williams, M.D. | John J. Cowan & Son | 510 Gilmor St. |

VS 150

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81245

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81245

BIRTH NO.

1. NAME OF DECEASED (Type or Print) THOMAS L. KENNEY

2. DATE OF DEATH 12/24/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) So. Baltimore Gen. Hosp.

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2416 E. Federal St.

5. SEX Male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 7/25/1913
9. AGE (In years last birthday) 36
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Credit manager
10B. KIND OF BUSINESS OR INDUSTRY Mfg Oil Burner
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin E. Kenney
14. MOTHER'S MAIDEN NAME Anna E. Shaneybrook

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ~
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Mrs Marie R. Kenney ADDRESS 2416 E. Federal

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Coronary occluson

DUE TO

(C) Coronary arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-23-1949 *to* 12-24-1949, *that I last saw the deceased alive on* 12-24-1949 *and that death occurred at* 2:50 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE Klein D. Grayson M.D.
23B. ADDRESS So. Balto. Gen. Hosp.
23C. DATE SIGNED 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/28/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State) 4430 Belair Rd.

DATE RECEIVED BY LOCAL REGISTRAR DEC 27 1949
REGISTRAR'S SIGNATURE Cuthbert for Williams, M.D.
25. FUNERAL DIRECTOR John J. Cowen & Son
ADDRESS 940 Hollins St.

VS 150

94a

G81246
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916.0 G81246
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): Athena D. Hillery
2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1721 W. Lanvale 16-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C. | | March 10, 1946 | 3 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Charles Hillery
14. MOTHER'S MAIDEN NAME: Geneva Carter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Charles Hillery ADDRESS: 1710 W Lanvale st

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) First and second degree burns of face and body estimated to be 30% total surface

DUE TO

(B) Carbon monoxide poisoning

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 1721 W. Lanvale St. 16/3
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 23, 1949 10 A m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR?: Conflagration

22. *I certify that I took charge of the remains described above, held an* Insp. & In. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Dec. 24, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 28, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem
24D. LOCATION (City, town, or county) (State): Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: George G. Kelson ADDRESS: 1303 Pennsylvania ave

VS-151

180

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. E 1949 68247

68247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 3409 N. Calvert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34th & Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** HOWARD BURTON ECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced. |
|---|---|---|
| male | white | married |

6 (b) Name of husband or wife Anna Louise Mayer Ecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1880

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 69 yrs. | | | hr. min. |

9. Birthplace New Windsor, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bank

FATHER
12. Name Elsworth Ecker
13. Birthplace New Windsor, Md.

MOTHER
14. Maiden Name Virginia Schwartz
15. Birthplace -

16 (a) Informant Mrs. Helen E. Peterman
(b) Address Greenway Apts., Charles & 34th

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/49 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1949 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1949, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 yrs 19 . to Dec 25 1949. and that I last saw h[illegible] alive on Dec 15 1949.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to Cardiac Insufficiency

Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 306 Univ. Pkwy. Date signed Dec 25 1949

VS 150

93 D

G81248

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

4/16

Registered No. G81248

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NEUKUM, MARY EVELYN

2. DATE OF DEATH 12/26/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEM. HOSPITAL

c. Length of stay in Baltimore: 61 YEARS (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY BALTIMORE
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 40 E. 27TH STREET

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M | 9/23/1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | | BALTIMORE | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JAMES TYLER GODMAN | ANNE A. Patterson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no - | | JOSEPH J. NEUKUM | 40 E. 27th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | CONGESTIVE HEART FAILURE | 2 WKS |
| DUE TO (B) | RHEUMATIC HEART DISEASE | LIFETIME |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | ARTERIAL EMBOLUS TO LEFT LEG. | 2? WKS |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/25, 1949, *to* 12/26, 1949, *that I last saw the deceased alive on* 12/26, 1949, *and that death occurred at* 8:45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A. Ranson M.D. | Union Memorial Hospital | 12-26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Loudon Park Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Timothy for Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81249

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

177 Registered No. G81249

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARTIN LAUFF

2. DATE OF DEATH: Dec. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4351 Reisterstown Rd.
c. Length of stay in Baltimore: 25 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4351 Reisterstown Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Nov. 23, 1883 | 66 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Designer | K. Katz & Son | Austria | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| - Lauff | Julia - |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | | Mrs. Mary Lauff | 4351 Reisterstown Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cancer of Prostate with Metastases

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| April 48 | Ca Prostate c Metastases | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Jan ____, 19 49 *to* Dec 25, 19 49, *that I last saw the deceased alive on* Dec 25 19 49 *and that death occurred at* 1 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 9033 W Northern | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/27/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | [signature] for Milliams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

51B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined for correct age is especially important. Physicians: please write the cause of death clearly and legibly.

081250

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Shipley 4201 081250 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): JESSE R. SHIPLEY

2. DATE OF DEATH: Dec. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 834 N. Bentalou St.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 834 N. Bentalou St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 30, 1890 | 59 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist (rtl) | Railroad | Balto., Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George T. Shipley | Bertha Teipel |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | | Mrs. Margaret S. Shipley | 834 N. Bentalou |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Coronary Occlusion. | 2 hr. |
| ANTECEDENT CAUSES | DUE TO (B) | Cardio vascular disease. | several yrs |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | — | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | — | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* — , 19[illegible] *to* Dec 25 , 1949 *that I last saw the deceased alive on* Dec 24 , 1949 *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M Brannan Hood M.D. | 2300 Jarvis Blvd | Dec 26-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/49 | Lorraine Mausoleum | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Thurston for Williams, MD | W. J. DICKNER & SONS, | Balto., Md. |

VS 150

93D

G81251

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81251

1. NAME OF DECEASED (Type or Print) MARGARET LOUISE DUNN

2. DATE OF DEATH Dec. 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Edgewood Nursing Home 6000 Ballona Ave.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4406 Garrison Blvd. 15-10

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year Months Days | If under 24 hours Hours Min. |
|---|---|---|---|---|---|---|
| female | white | widowed | Jan. 13, 1867 | 82 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | at home | Baltimore, Md. | |

13. FATHER'S NAME William Seidler

14. MOTHER'S MAIDEN NAME Sophia Ide

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Mrs. Alma Laukaitis | 4406 Garrison Blvd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 da

DUE TO

(B) Generalized Arteriosclerosis — 5 yrs

DUE TO

(C) Cardiovascular Disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/25/49, 19 , *to* 12/25, 1949 *that I last saw the deceased alive on* 12/25, 1949, *and that death occurred at* 4:34 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph Laukaitis M. D. | 679 Washington Blvd | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81252

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 Registered No. G81252

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) Nellie Schwartz — 2. DATE OF DEATH 12-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 424 S. Elrino St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto 24 Md.

c. Length of stay in Baltimore 1 year (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location) 424 S. Elrino Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | W. | Widowed | 6-18-74 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Home | New York | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Valentine Poodach | Mary Holtzer |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| V | | Mrs. Luther Herr - 424 S. Elrino St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hypertensive Cardio- — DUE TO Arteriosclerosis

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 10-21 1949 *to* 12-26, 1949, *that I last saw the deceased alive on* 12-26 1949, *and that death occurred at* 9:35 Am., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E.A. Hourigan Jr. M.D. | 3503 Fait Ave | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | 12/27/49 | Greenfield - | Long Island - N. York |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Tully & Zeller Inc - 403 E. Wolfe St |

VS 150

93D

G81253 ✓

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 741

Registered No. G81253

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOHN DUSZYNSKI

2. DATE OF DEATH: 12/25/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH BALTO GENERAL HOSP

c. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 1217 S DECKER AVE 1-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | JUNE 23 1901 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| NONE | | BALTIMORE | U.S.A. |

13. FATHER'S NAME: JOHN DUSZYNSKI

14. MOTHER'S MAIDEN NAME: ROSA PRICE

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | NONE | HENRY DUSZYNSKI | 1217 S DECKER AVE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

(B) Chronic bronchial asthma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-24-49 *to* 12-25-1949, *that I last saw the deceased alive on* 12-25-1949, *and that death occurred at* 9:55 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D. Jaffe M. D. | So. Balto Gen Hosp | 12/25/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) | (State) |
|---|---|---|---|---|
| BURIAL | DEC 29 1949 | HOLY CROSS NATIONAL CATHOLIC | GERMAN HILL | RD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams M.D. | Duffel Bros | 1500 E LOMBARD ST. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

112

G81254

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81254

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Raymond H. Siepert

2. DATE OF DEATH: Dec 24-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 42C N HIGHLAND AVE

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.

c. Length of stay in Baltimore: 35 Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 426 N. Highland Ave

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | April 16 1896 | 53 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Opt.

10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Co.

11. BIRTHPLACE (State or foreign country): Chicgo. Ill.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No

(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: 212-10-5702

17. INFORMANT: Lena Siepert ADDRESS: 426 N. Highland Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) metastatic carcinoma of abdomen — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Carcinoma of bladder — 16 mos

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: Aug 1948

19B. MAJOR FINDINGS OF OPERATION: Carcinoma of bladder

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22, 1949 *to* 12-24, 1949 *that I last saw the deceased alive on* 12-24-1949 *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: John J Gould M. D.

23B. ADDRESS: 14 N Eutaw

23C. DATE SIGNED: 12-25-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Dec 27-49

24C. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cem

24D. LOCATION (City, town, or county) (State): Woodlawn Balto. Co

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR: Riggel Bro. ADDRESS: 1800 E. Lombard St

VS 150

520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct are is especially important. Physician: please write the cause of death clearly and legibly.

G81255

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81255 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maude Kleinhen

2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Agnes Hospital
c. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1517 Ramsay St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | 5/28/1889 | 60 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Md. | U.S.A. |

13. FATHER'S NAME: Tony Tracy (dec'd)

14. MOTHER'S MAIDEN NAME: Georgia ? FOWLER

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Harry Kleinhen | 1517 Ramsay St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive heart failure
DUE TO
(B) Arteriosclerotic CVD
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ?

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/23, 19 49 *to* 12/27, 19 49 *that I last saw the deceased alive on* 12/27, 19 49 *and that death occurred at* 1:55 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Gerhard W. Lanchner M.D. | St Agnes Hospital | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Loudon Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR |
|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | for H.C. & P.M. Walters Street Md |

VS 150

93

G81256

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

71.0

G81256

Registered No.

BIRTH NO. 49-19798

1. NAME OF DECEASED (Type or Print) Richard [illegible] Figgs

2. DATE OF DEATH 12-23-49

3. PLACE OF DEATH
A. Baltimore City, Maryland — University Hosp.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
c. Length of stay in Baltimore 3 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
107 N. Bruce St. Baltimore 17
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 107 N. Bruce St. 19-24

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Single | 9-15-49 | | 3 Mo | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | Infant | Baltimore | USA |

13. FATHER'S NAME Ralph Pratt

14. MOTHER'S MAIDEN NAME Doris Figgs

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Anoxia — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Hyaline membrane — DUE TO

(C) Prematurity — 3 days

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| None | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| None | None | None |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| None m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-23, 19 49 *to* 12-23, 19 49, *that I last saw the deceased alive on* 12-23, 19 49, *and that death occurred at* 4:57 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Friedman M.D. | University Hosp. | 12-23-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-27-1949 | W.F. Auburn Cem. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Walter R. Williams | 3229 Sehoolfield St. |

VS 150

1192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81257

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

49-8 G81257

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma Murphy

2. DATE OF DEATH: December 22, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4730 Round Count

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widowed | - -1887 | 62 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houseg
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sandy Corbin
14. MOTHER'S MAIDEN NAME: Maggie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
If yes, give war or dates of service:
16. SOCIAL SECURITY NO.
17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO
(B) cancer - primary site undetermined
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-18, 1949, *to* 12-22, 1949 *that I last saw the deceased alive on* 12-22, 1949, *and that death occurred at* 8 05 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Wasten Amos M. D.
23B. ADDRESS:
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-27-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs. Katie P. Williams
ADDRESS: 3299 Sahsondale

VS 150

55E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GARNES ✓

G81258 — BALTIMORE CITY HEALTH DEPARTMENT — 331 — G81258

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hannah Garnes

2. DATE OF DEATH: Dec 24/49 — 205 PM

3. PLACE OF DEATH: A. Baltimore City, Maryland — 1 DUKE W Fayette

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 55 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1548 W. Fayette St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Fem | Col | Widow | 11-24-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Mason Ky | |

13. FATHER'S NAME: Robert Garnes

14. MOTHER'S MAIDEN NAME: Nancy Fitts

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Joseph Garnes | 1548 W Fayette St |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — Interval between onset and death: 12/24/49

DUE TO

(B) Hypertension & arteriosclerosis — 3 Wks

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | None | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/3, 1949 *to* 12/24, 1949 *that I last saw the deceased alive on* 12/24/49, 19__, *and that death occurred at* 12 P m. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H Ridenour M. D. | 1131 Harlem Ave | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Hospital | 12-27-1949 | Morlina G. C. | Morlina G. C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Mrs Katie R. Williams | 3297 Schroeder |

Vs 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81259

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G81259

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES Brooks

2. DATE OF DEATH: Dec. 24, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2111 N. HOWARD St.

b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 12 07
D. STREET ADDRESS (If rural, give location): 2111 N. HOWARD St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | Colored | MARRIED | Dec. 7, 1873 | 76 | | 17 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| JANITOR | | MARYLAND | U.S.A. |

13. FATHER'S NAME: Augustus Brooks

14. MOTHER'S MAIDEN NAME: MARTHA JONES

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | MARGARET Brooks | 2111 N. Howard St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Acute Pulmonary Congestion | Several days |
| DUE TO (B) | Hypertensive Cardio Vascular Disease | Unknown |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Probable Peptic Ulcer | Unknown |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* October 20, 1949, *to* December 24, 1949, *that I last saw the deceased alive on* 12-24-, 1949, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Richard H. Hunt M.D. | 1631 W. Franklin St. | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-28-49 | Mt Auburn Cem | Baltimore Md 5782 Biddle St |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | [illegible] | Mrs Frances A Hemsley | 93D |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81260

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81260

BIRTH NO. 49-28553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): BABY BRUMSON

2. DATE OF DEATH: December 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 925 Hanover Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | — | Dec 22-49 | | 4 3 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Balto Md | |

13. FATHER'S NAME: Louis Brumson

14. MOTHER'S MAIDEN NAME: Mildred Puck

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mildred Brumson | 925 Hanover St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemorrhagic disease of the newborn with extensive hemorrhagic pulmonary consolidation

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: R. B. Fisher M.D. | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: Dec. 26, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | H-28-49 | Mt. Calvary Cemtry | Balto |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR'S SIGNATURE: Tuntington Williams M.D.

25. FUNERAL DIRECTOR: W. B. Spriggs

ADDRESS: 13 W Hamburg St

161c

VS 151

G81261

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

451

Registered No. G81261

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CARMINE CIOTOLA

2. DATE OF DEATH December 23, 1949

3. PLACE OF DEATH: A Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 335 S. Gilmore Street 19 03

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 1st 1885
9. AGE (In years last birthday): 64 — If under 1 Year: Months 5, Days 22 — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Section Foreman
10B. KIND OF BUSINESS OR INDUSTRY: Balt.Ohio R.R.
11. BIRTHPLACE (State or foreign country): Castel Pizzuto Italy
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Dominic Ciotola
14. MOTHER'S MAIDEN NAME: Josephine ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 705-09-0106
17. INFORMANT: Joseph Ciotola ADDRESS: 9 N.Beechfield Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac tamponade
DUE TO
ruptured aneurysm of the aorta
(B) Arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e.g. In or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: W. J. McCafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 27 1949
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State): 4300 Old Frede. Rd. Balti. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, MD
25. FUNERAL DIRECTOR: Frank Della Rocca ADDRESS: 322 S. High St.

VS 151

96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81262

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81262

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mrs. Katherine McGeorge

2. DATE OF DEATH Dec. 27, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Pennsylvania
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orrtanna
d. STREET ADDRESS (If rural, give location) Mt. Crest Orchards

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Div. | Feb 2-1888 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| - - - | — | Japan | |

13. FATHER'S NAME: ALFRED LARGE

14. MOTHER'S MAIDEN NAME: ELIZABETH J. SPENCER

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Mrs Elizabeth McGeorge | 3010 Kenwood Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary oedema

DUE TO

(B) Infarction of Myocardium due to arteriosclerotic Coronary thrombosis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES XX NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12/27/ , 1949 to 12/27/ , 1949 that I last saw the deceased alive on 12/27/ , 1949 , and that death occurred at 1:25 AM, from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| S. K. Kaan M.D. | 1400 N. Caroline Street | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 12/28/49 | Greenmount Cem | Baltimore, Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | Leonard J Rusk | 5305 Harford Rd |

45 150

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully verified and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81263

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81263

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William H. Simpson

2. DATE OF DEATH: Dec. 25. 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 417 E. Chase Street

c. Length of stay in Baltimore: 77 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write the name of township): Baltimore
D. STREET ADDRESS (If rural, give location): 417 E. Chase St. 10 1

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 25. 1877
9. AGE (In years last birthday): 72 (Under 1 Year: Months Days; Under 24 Hours: Hours Min.): 0 0
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): I
10B. KIND OF BUSINESS OR INDUSTRY: Butcher
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph H. Simpson
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Genevieve M. Simpson ADDRESS: 417 E. Chase St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | Primary Atyical Pneumonia | 1 wk. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Diabetes Mellitus | 10 yrs. |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT SUICIDE HOMICIDE (Specify):
21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW INJURY occurred:

22. I hereby certify that I attended the deceased from Sept. 49 to Dec. 25 1949 that I last saw the deceased alive on Dec. 24, 1949, and that death occurred at 9A. m., from the causes and on the date stated above.

23A. SIGNATURE: Wm. H. Kamman, Jr. M.D.
23B. ADDRESS: 701 Sheridan Ave.
23C. DATE SIGNED: Dec. 27, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Yes
24B. DATE: Dec. 28 1949
24C. NAME OF CEMETERY OR CREMATORY: Baltimore Cemetery
24D. LOCATION (City, town, or county): Baltimore State: Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Elmer McConkliss ADDRESS: 924 E. Eager St.

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

# CERTIFICATE CORRECTED 1-5-50

G81264

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

760

G81264

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mr. John Valentine Ullrich

2. DATE OF DEATH: Dec. 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1421 Holbrook St. 9-09

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 7, 1887
9. AGE (In years last birthday): 62
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boxmaker
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles M. Joseph Ullrich
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary E. Ullrich - Above.
ADDRESS

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Diabetic Coma

DUE TO

(B) Diabetes Mellitus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Acute Pulmonary oedema

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/26/ , 1949, *to* 12/26/ , 1949, *that I last saw the deceased alive on* 12/26/ , 19 49, *and that death occurred at* 9:05 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: S. K. Kaan M. D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Bur
24B. DATE: 12/30/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.
24D. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Lucretia for Williams, M.D.
25. FUNERAL DIRECTOR: Elmer W. Conklin
ADDRESS: 924 E. Eager St

VS 150

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81265

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81265 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Charles L. W. Butler

2. DATE OF DEATH: Dec. 25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1432 Millrace Rd.
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 1432 Millrace Rd. 12 08

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct 31 1865
9. AGE (In years last birthday): 84 — If under 1 Year: Months, Days — If under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired millhand
10B. KIND OF BUSINESS OR INDUSTRY: Textile mill
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm Butler
14. MOTHER'S MAIDEN NAME: Mary Nay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph E. Butler — ADDRESS: 1509 Millrace Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypostatic

DUE TO

(B) Pneumonia Lobar

DUE TO

(C) Acute Cerebral Thrombosis Etc

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) 96hrs
(B) 7hrs
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 24th, 1949 *to* Dec 25th, 1949 *that I last saw the deceased alive on* Dec 25-49, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Bert A. Zuerich M.D.
23B. ADDRESS: 3414 Falls Rd. Balto 11
23C. DATE SIGNED: Dec 26 49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec 28 1949
24C. NAME OF CEMETERY OR CREMATORY: St Mary's
24D. LOCATION (City, town, or county) (State): Govanden.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Timothy for Williams M.D.
25. FUNERAL DIRECTOR: Frank E. Greenwood & Sons — ADDRESS: 3615-17 Edmondson Ave

VS 150

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81266

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81266

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CHARLES L. SMITH

2. DATE OF DEATH 12/25/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-07
D. STREET ADDRESS (If rural, give location) 2704 Miles Ave.

3. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pronounced Dead at Union Memorial Hospital

c. Length of stay in Baltimore — Yrs. Mon. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | married | July 1, 1875 | 74 | — | — |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard, Woolworth Store
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Charles Smith
14. MOTHER'S MAIDEN NAME Mollie Taylor
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mamie L. Smith ADDRESS 2704 Miles Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) acute pulmonary edema
DUE TO
(B) Hypertensive cardiovascular disease
DUE TO
(C) nephrosclerosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
R. S. Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION —
19B MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I hereby certify that I attended the deceased from* ____, 19 D.O.A. ____, 19 __, *that I last saw the deceased alive on* ____, 19 __, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE Charles H. Watt Jr., M. D.
23B. ADDRESS Union Memorial Hospital
23C. DATE SIGNED 12/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/28/49
24C. NAME OF CEMETERY OR CREMATORY Lorraine Park
24D. LOCATION (City, town, or county) (State) Woodlawn Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Hurd E. Landmesser ADDRESS 3811 W. Belvedere Ave.

VS 150

1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81267 — MARIE A — BALTIMORE CITY HEALTH DEPARTMENT — G81267

BIRTH NO. — **CERTIFICATE OF DEATH** — Registered No.

1. NAME OF DECEASED (Type or Print): Agnes Hayne — 2. DATE OF DEATH: 12/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Mercy Hosp.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

C. Length of stay in Baltimore: Life — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 9-08
D. STREET ADDRESS (If rural, give location): 1923 Homewood Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | | Oct 27, 1902 | 47 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Rowley
14. MOTHER'S MAIDEN NAME: Margaret Reardon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO: none
17. INFORMANT: Mr. Warren H. Hayne, Husband — ADDRESS: same

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH — WARREN HENRY HAYNE.

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year?
DUE TO
(B) probably originating from pelvis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: 12/24/49
19B. MAJOR FINDINGS OF OPERATION: Metastases in liver
20. AUTOPSY? YES [ ] NO [X]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/22/49, 19—, *to* 12/25/49, 19—, *that I last saw the deceased alive on* 12/25/49, 19—, *and that death occurred at* 1:47 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: H. Kaskin, M. D. — 23B. ADDRESS: Mercy Hospital — 23C. DATE SIGNED: 12/25/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24B. DATE: 12-28-49 — 24C. NAME OF CEMETERY OR CREMATORY: St. Peters — 24D. LOCATION (City, town, or county) (State): Katy City

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949 — REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: WIEDEFELD & SON, GREENMOUNT AVE & 22ND

VS 150

55E

G81268

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81268

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HARRY W. AULBACH

2. DATE OF DEATH: December 25, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2917 Guilford Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2917 Guilford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | August 13, 1892 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Draftsman | Shipyard | Baltimore, Md. | U.S.A. |

13. FATHER'S NAME: William H. Aulbach

14. MOTHER'S MAIDEN NAME: Mary Gebelein

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No. | | Mrs. Katherine Fuller 2917 Guilford Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 1945, *to* Dec. 25, 1949 *that I last saw the deceased alive on* Dec. 24, 1949 *and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry M. Hansen M. D. | 20 E. Preston St. Balto-2 | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 28, 1949 | London Park | Baltimore, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR'S SIGNATURE: Huntington Williams, MD

25. FUNERAL DIRECTOR ADDRESS: Ullrich Funeral Home 2008 Orleans St.,

VS 150

130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81269

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81269

BIRTH NO.

1. NAME OF DECEASED (Type or Print) GEORGE BOELLNER

2. DATE OF DEATH Dec. 24, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 928 E. 20th St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 928 E. 20th St. 9-08

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 14, 1874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Baker | Bakery | Germany | |

13. FATHER'S NAME Michael Boellner

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Otto Boellner | 928 E. 20th St. |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary thrombosis | Immediate |
| DUE TO | Hypertensive cardio vascular disease. | about 4 years. |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO | | |
| (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12/20/45, 19__, *to* 12/24/, 1949 *that I last saw the deceased alive on* 12/24/ 1949, *and that death occurred at* 10 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Boilel, M. D. | 1226 Hanover Street | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 28, 1949 | Lorraine Cemetery | Woodlawn, Md. |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949

REGISTRAR'S SIGNATURE: Remington Williams, M.D.

25. FUNERAL DIRECTOR — ADDRESS: Ullrich Funeral Home 2009 Orleans St.

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81270

BIRTH NO. 49-19776

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

191 Registered No. G81270

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) WILLIAM E JENKINS

2. DATE OF DEATH December 25, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Maryland
B COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodstock
D STREET ADDRESS (If rural, give location)

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1423 Cavendish Way

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | Single | Sept. 14, 1949 | | 3 / 11 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10B. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles R. Jenkins
14. MOTHER'S MAIDEN NAME Mary Rudasill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO —
17. INFORMANT Mrs. Mary Jenkins, ADDRESS Woodstock Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION — 19B. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE R S Fisher M.D.
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED Dec. 25, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28-49 | St. Marys (Hampden) | Baltimore |

DATE RECEIVED BY LOCAL REGISTRAR DEC 27 1949
REGISTRAR'S SIGNATURE Initials for Williams, MD
25. FUNERAL DIRECTOR Frank W. Seitz ADDRESS 814 W. 36th Street

VS 151

107

G81271

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 90 2.3 G81271 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Patrick Boland N-805-v

2. DATE OF DEATH: Dec. 24, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 703 McKewin Ave. 9-6-3

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital

c. Length of stay in Baltimore: 4 2 (Yrs. / Mos. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | MARRIED | Sept. 1, 1907 | 42 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elec. Welder
10B. KIND OF BUSINESS OR INDUSTRY: Beth. Steel Corp
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wm. Boland
14. MOTHER'S MAIDEN NAME: Bridget Byrne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 215-01-3190
17. INFORMANT: Mrs Mary Boland ADDRESS: 4513 Marbleshall Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemothorax right
DUE TO Multiple fractures ribs
(B) Retroperitoneal hemorrhage
DUE TO Fracture lumbar vertebrae 1-3
(C) Fracture pelvis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): shipyard
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Key Highway Shipyard 24/2
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: Dec. 21, 1949 1 P m.
21E. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR? [illegible] welding, on scaffold [illegible] fell to bottom of tank

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty M.D
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED: Dec. 24, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 12-28-49 | New Cathedral | Baltimore Md |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Curtington Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran ADDRESS: 3000 E. Balto St.

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81272

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81272

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print): George Joseph Trageser

2. DATE OF DEATH: 12-26-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital
c. Length of stay in Baltimore — Yrs. / Mos. / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MARYLAND
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 4609 York Rd

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 10-4-74
9. AGE (In years last birthday): 75 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joseph Trageser
14. MOTHER'S MAIDEN NAME: MARY THALHEIMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mrs Cecilia M. Kennedy — ADDRESS: 4613 York Rd

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute Pulmonary Oedema
DUE TO
(B) Coronary Heart Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26, 1949 *to* 12-26, 1949, *that I last saw the deceased alive on* 12-26, 1949, *and that death occurred at* 6:15 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: E. K. Kaan M. D.
23B ADDRESS:
23C DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: 12-29-49
24C. NAME OF CEMETERY OR CREMATORY: Lowden Park
24D LOCATION (City, town, or county) (State): BALTIMORE Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Evington Williams, M.D.
25 FUNERAL DIRECTOR: John A. Moran — ADDRESS: 3000 E. Balto St.

VS 150

94a

G81273

BALTIMORE CITY HEALTH DEPARTMENT 43

# CERTIFICATE OF DEATH

G81273

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Miss Elizabeth Maxwell Carroll

2. DATE OF DEATH Dec. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 12-02

D. STREET ADDRESS (If rural, give location) The Freeway 4th Balto 18 mo

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Fe. | White | Single | Nov. 26, 1868 | 81 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | — | Balto. Md. | U.S.A. |

13. FATHER'S NAME Mr. Samuel S. Carroll

14. MOTHER'S MAIDEN NAME Rebecca Thompson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| — | — | Self | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure — Interval between onset and death: 26 days

DUE TO

(B) Hypertensive Cardiovascular Disease — Interval between onset and death: 15-20 yrs

DUE TO

(C) R. B. Fisher M.D. — Interval between onset and death:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture of Left Hip + Lt. Wrist — Interval between onset and death: 30 days

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov. 15, 1949 | Colle's Fracture of left wrist | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | home | The Freeway apt. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| Nov. 18, 1949 3 P m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Fell in home slipped and |

22. I hereby certify that I attended the deceased from Nov. 18, 1949, to Dec. 27, 1949, that I last saw the deceased alive on Dec. 27, 1949, and that death occurred at 3:10 A m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A. Kavan M.D. | Union Memorial Hospital | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 12/28/49 | Greenmount Crematory | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | Wm. J. TICKNER & SONS | Balto. Md. |

VS 150

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81274

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81274

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George W. Kemp

2. DATE OF DEATH Dec. 27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 832 N. Woodington Rd.

C. Length of stay in Baltimore 70 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 832 N. Woodington Rd. 16-08

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Feb. 22, 1877
9. AGE (In years last birthday) 72 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10B. KIND OF BUSINESS OR INDUSTRY Rice Bakery
11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Kemp
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216 01 9705
17. INFORMANT A, Mrs. Ruth Kemp, 832 N. Woodington Rd ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: one day
DUE TO (B) arteriosclerotic type heart disease with coronary hypertrophy and congestive failure. — several years.
DUE TO (C) Generalized arteriosclerosis with hypertension

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

Chronic Bronchitis & bronchial asthma

19A. DATE OF OPERATION None
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 15, 1949 *to* Dec' 27, 1949, *that I last saw the deceased alive on* Dec 27 1949, *and that death occurred at* 7.00 A. m., *from the causes and on the date stated above.*

23A. SIGNATURE Wm Nisbet M. D.
23B. ADDRESS 1015 Poplar Grove St
23C. DATE SIGNED Dec 27 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/30/49
24C. NAME OF CEMETERY OR CREMATORY Lorraine Pk. Woodlawn, Maryland
24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR DEC 27 1949
REGISTRAR'S SIGNATURE Huntington Williams, MD
25. FUNERAL DIRECTOR Harry A. Wright
ADDRESS 4101 Edmondson Ave.

VS 150

93D

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81275

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81275

BIRTH NO.

1. NAME OF DECEASED (Type or Print): REBECCA M SWARTZ

2. DATE OF DEATH: Dec. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3902 EDMONDSON AVE
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 16 06
D. STREET ADDRESS (If rural, give location): 3902 EDMONDSON AVE

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | WIDOW | APRIL 4, 1860 | 89 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): PENNA
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: CROUL
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.

17. INFORMANT: MRS DOROTHY CORBIN
ADDRESS: 3902 EDMONDSON

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(B) arteriosclerosis
DUE TO
(C) Senility - old age

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-12 19 .., *to* 19 .., *that I last saw the deceased alive on* 12-24 1949 *and that death occurred at* 5:20 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. W. Schey M. D. | 3921 Edmondson | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | Dec. 28 '49 | ST. JOSEPH'S | HANOVER PA |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | HARRY H WITZKE | 3701 EDMONDSON |

VS 150

H. W. SCHEYE

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81276 Carodine X

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. G81276

1. NAME OF DECEASED (Type or Print): Eugene Carodine

2. DATE OF DEATH: 12/25/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 855 Ostend St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): none — 855 W Ostend St

C. Length of stay in Baltimore: 1 day (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY: Queen Anne
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester
D. STREET ADDRESS (If rural, give location): R.F.D.

5. SEX: M
6. COLOR OR RACE: Col'd
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): ~~MARRIED~~
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 66 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.: Unknown

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10B. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Queen Anne Co. Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Carodine
14. MOTHER'S MAIDEN NAME: Henretta Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 212-16-4203
17. INFORMANT: Calvin Carodine — ADDRESS: Queen Anne

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED — WHILE AT WORK ☐ — NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: Earl L Royer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 25 Dec 49

24A. BURIAL, CREMATION, REMOVAL (Specify): 24B. DATE: 12/28/49
24C. NAME OF CEMETERY OR CREMATORY: Chester Church
24D. LOCATION (City, town, or county) (State): Queen Anne Co. Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Leon W. Henry — ADDRESS: Easton Md.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81277

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81277

BIRTH NO.

1. NAME OF DECEASED (Type or Print) — AMY LEE RADER

2. DATE OF DEATH — Dec. 25, 1949

3. PLACE OF DEATH
X. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE — Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) — Baltimore
D STREET ADDRESS (If rural, give location) — 1111 S. Carey St.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) — 1111 S. Carey St.

c. Length of stay in Baltimore — Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | Jan 21, 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Maryland | |

13. FATHER'S NAME — George Rodenhiser

14. MOTHER'S MAIDEN NAME — Emma Hemsing

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT — ADDRESS |
|---|---|---|
| No | None | Chester S. Rader, 1211 W. Lafayette Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Hypertension and arteriosclerotic Cardio-vascular disease — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 10 hours.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 14 Dec, 1949 *to* 25 Dec 1949, *that I last saw the deceased alive on* 25 Dec, 1949, *and that death occurred at* 12 M p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Emil H. Henning Jr. M.D. | 601 Winans Way | 27 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/49 | Western | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| DEC 27 1949 | Huntington Williams, M.D. | William Cook, Inc., 1217 St. Paul St. |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Carefully supply correct age is especially important. Physician: please write the cause of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 681278

BIRTH NO. 681278

1. NAME OF DECEASED (Type or Print): Isaac B. Hicks

2. DATE OF DEATH: December 25, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland 941 Mayadon Court

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 941 Mayadon Court

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Feb. 17, 1906 | 43 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Chemical- Operator | Brooklyne Chemical Co. | Fair Chance, Penna. | |

13. FATHER'S NAME: Hicks

14. MOTHER'S MAIDEN NAME: Sarah L. Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 210-10-8120 | Mrs. Anna Hicks (Wife) | 941 Mayadon Ct. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Insufficiency

DUE TO [illegible] arteriosclerotic heart disease.

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

(Autopsy, Inspection or Inquiry)

| 23a. SIGNATURE | 23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23c. DATE SIGNED |
|---|---|---|
| Carl L Royer M.D. | | 25 Dec 49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Removal | Dec. 26, 1949 | Salem View | New Salem Pa. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | William Cook, Inc. | 1217 St. Paul Street |

VS 151

92a

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81279

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

19 Registered No. G81279

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Theresa B. Stoffels

2. DATE OF DEATH: Dec. 26, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 218 E. University Parkway

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1301 Park Ave.

c. Length of stay in Baltimore: 1301 Nurses Home — 40 yrs (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | About 70 | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Becker
14. MOTHER'S MAIDEN NAME: Theresa Tschudy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: F. Milton Becker, ADDRESS: 524 Normandy Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Tumor of R. Kidney (Wilms) —
DUE TO
(B) probably benign
DUE TO
(C) Glaucoma 7yr.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) 1 yr —
(B) 1 wk
(over)
(C)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June, 1947, *to* Dec. 26, 1949, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Henry E. Nolan M. D.
23B. ADDRESS: 3 W. Biddle
23C. DATE SIGNED: 12-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/28/49
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: H. H. Mears and Son. ADDRESS: 805 N. Calvert St.

VS 150

56E

PLEASE WRITE LEGIBLY. WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Special attention is especially important.

G81280

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81280

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Melcher Carroll Corcoran

2. DATE OF DEATH: 12-27-49

3. PLACE OF DEATH: a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glen Arm
D. STREET ADDRESS (If rural, give location): Manor Rd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Oct 2, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Farming | Maryland | U.S.A. |

13. FATHER'S NAME: Christopher Corcoran

14. MOTHER'S MAIDEN NAME: Cynthia Fowble

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| Unknown | | Mr Leslie Horton | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chemical peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Perforated duodenal ulcer

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-26 19 49 *to* 12-27, 19 49, *that I last saw the deceased alive on* 12-27, 19 49, *and that death occurred at* 12 30 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John S. Green, M.D. | Union Memorial Hosp | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| BURIAL | Dec. 30, 1949 | TRINITY CEMETERY | LONG GREEN, MD. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Nathanson, M.D. | JOHN BURNS' SONS, | TOWSON, MD. |

1176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered correctly. Be sure that the information about the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81281

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81281

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY GORRERA

2. DATE OF DEATH: 12-21-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2232 Barclay St.

c. Length of stay in Baltimore: Yrs. life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2232 Barclay St. 12 04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED OR DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1859 | 90 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| --- | ---- | Baltimore, Md. | |

13. FATHER'S NAME: John Milburn

14. MOTHER'S MAIDEN NAME: Mary Milburn

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | - | - | Mrs. Hawkins | 2232 Barclay St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Respiratory failure

DUE TO

(B) Arteriosclerotic Cardio - vascular renal disease

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* December, 1948 *to* December 21, 1949 *that I last saw the deceased alive on* Dec 18, 1949 *and that death occurred at* 6:30 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| I. Sborofsky M.D. M. D. | 601 N. Monroe St. | 12/23/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/24-49 | Parkwood | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 27 1949 | Huntington Williams, MD | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

VS 150

131a

CAUSE WRITE PLAINLY IN INK. Entry of information should be typewritten. Physician: please write the cause of death clearly and legibly. correct age is especially important.

BB-134476
G81282

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81282 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Robertson Kay

2. DATE OF DEATH: 12-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
c. Length of stay in Baltimore: 16 Mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Baltimore~~ Dundalk
D. STREET ADDRESS (If rural, give location): 6722 Woodley Road (22)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 14, 1897 | 52 | 5 / 13 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mold loftsman
10B. KIND OF BUSINESS OR INDUSTRY: Ship building
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George ?
14. MOTHER'S MAIDEN NAME: Jessie McMillan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 024037368
17. INFORMANT: Records*Balto. City Hospitals ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Beri Beri Heart Disease
DUE TO
(B) Avitaminosis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Delerium Tremins.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26 1949 *to* 12-27 1949, *that I last saw the deceased alive on* 12-27 1949, *and that death occurred at* 8:45 A. M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 4940 Eastern Avenue
23C. DATE SIGNED: 12-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/27/49
24C. NAME OF CEMETERY OR CREMATORY: Quincy Cem.
24D. LOCATION (City, town, or county) (State): Quincy, Mass.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 27 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jas H. Lyons
ADDRESS: 4001 Ritchie Hwy

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered, or the word unknown inserted. Information should be accurate, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81283

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

150

Registered No. G81283

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William H. Neubert

2. DATE OF DEATH 12/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Balto. Genl Hospital

C. Length of stay in Baltimore Yrs. 16 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto.
D. STREET ADDRESS (If rural, give location) 624 N. Pulaski st.

5. SEX Male
6. COLOR or RACE White
7. ~~SINGLE, MARRIED~~, ~~WIDOWED~~, DIVORCED (Specify) Divorced
8. DATE OF BIRTH 11/8/1879
9. AGE (In years last birthday) 70
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10B. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John A. Neubert
14. MOTHER'S MAIDEN NAME Sophia Gardner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. D. Pittman ADDRESS 624 N. Pulaski st.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma Esophagus
DUE TO
(B) Metastasis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
(A) June '48
(B) Dec '49
(C)

19A. DATE OF OPERATION 12-13-49
19B. MAJOR FINDINGS OF OPERATION Ca. Esophagus + Stomach
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-12, 1949 *to* 12-27, 1949 *that I last saw the deceased alive on* 12-27, 1949 *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23A. SIGNATURE Wilbur W. Biderman M.D. M. D.
23B. ADDRESS WBGH
23C. DATE SIGNED 12-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12/30/49
24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer
24D. LOCATION (City, town, or county) (State) Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS Wm. Cook Inc. 1217 St. Paul St.

VS 150

4612

G81284

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 44

G81284

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry Adam Gross

2. DATE OF DEATH: Dec 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 331 Scott St.
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 331 Scott Street 2 1 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | [illegible] 20, 1861 | 88 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | | Leading, Penna | |

13. FATHER'S NAME: Unknown Gross

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 215-16-6919

17. INFORMANT — ADDRESS: Mrs. Carrie L. Gross 331 Scott St Balto

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Nephrosclerosis Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

(C) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 9, 1949 *to* Dec. 27, 1949 *that I last saw the deceased alive on* Dec. 15, 1949 *and that death occurred at* 11:45 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| B. Kulicky, M.D. M. D. | 244 N. Milton St | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 29, 49 | St. Peters | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR — ADDRESS |
|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Wm Cook Inc 1217 E. Baltimore St, Balto, Md. |

VS 150

131a

Please write clearly and legibly. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

G81285

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 816.4

G81285 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MINNIE I. LAVINE — N-805.v

2. DATE OF DEATH December 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Union Memorial Hospital

C. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 3610 Glen Avenue 27-20

| 5. SEX | 6 COLOR OR RACE | 7 SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| female | white | married | | 42 | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Home wife | | Baltimore Md | |

13. FATHER'S NAME Nathan Bernstein

14. MOTHER'S MAIDEN NAME Dora

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Samuel Lavine | 3610 Glen Ave |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Fracture of vertebrae c-7 c-1 & 2 Multiple fractures, ribs, left clavicle right humerus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING ~~CAUSE OF~~ DEATH | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | street | Belvedere and Hillen Rd. 27/28 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 26, 1949 9.00p.m | WHILE AT WORK ☐ NOT WHILE AT WORK X | Auto Auto collision (Passenger) |

22 *I certify that I took charge of the remains described above, held an* autopsy *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident X, suicide ☐, homicide ☐, undetermined ☐.*

| 23A SIGNATURE | 23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER X MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | Dec. 27, 1949 |

| 24A BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-29-49 | United Hebrew | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Thurston for Williams, M.D. | Jack Kewoodre | 2100 Eutaw Pl |

VS 151

170c

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81286

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

570 ✓ Registered No. G81286

BIRTH NO

1. NAME OF DECEASED (Type or Print): Kramer, Rebecca

2. DATE OF DEATH: 12/22/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hospital
C. Length of stay in Baltimore: 60 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write R.F.D. and give township): Baltimore, Md. 15-13
D. STREET ADDRESS (If rural, give location): 2631 Loyola Northway

5. SEX: F
6. COLOR or RACE: W
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): M
8. DATE OF BIRTH
AGE (In years. If under 1 year, Months, Days, Hours, Min.): 65

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis
14. MOTHER'S MAIDEN NAME: Eva

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Joseph Kramer 2631 Loyola Northway

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
(A) Peritonitis & Intestinal Obstruction
DUE TO
(B) Massive Mesenteric Thrombosis

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO
(C) A.S.H.D. Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Uremia

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ✓

21A. ACCIDENT SUICIDE HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY occur?

22. I hereby certify that I attended the deceased from 12-23 1949 to 12-27 1949 that I last saw the deceased alive on 12-27 1949 and that death occurred at 6:45 P.M., from the causes and on the date stated above.

23A. SIGNATURE: [signature] M.D.
23B. ADDRESS: Sinai Hosp.
23C. DATE SIGNED: 12/21/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-28-49
24C. NAME OF CEMETERY OR CREMATORY: Rosedale
24D. LOCATION (Town, County, State): Potts Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949
REGISTRAR'S SIGNATURE: Thurlington for Williams, M.D.
27. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

61

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81287

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

1974 Registered No. G81287

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILMA ISCH SCHIFFNER

2. DATE OF DEATH: Dec. 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1416 N. Broadway

c. Length of stay in Baltimore: 31yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1416 N. Broadway 8 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Mar. 9, 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Virginia | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? Flaherty | ? Cooksey |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S NAME AND ADDRESS |
|---|---|---|
| no | none | 1416 N. Broadway Mr. Theodore Schiffner |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Uterus — INTERVAL BETWEEN ONSET AND DEATH: 4 yr
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month / Day / Year / Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 7/10 *,* 19 45 *, to* 12/25 *,* 19 49 *, that I last saw the deceased alive on* 12/25 *,* 19 49 *, and that death occurred at* ____ *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Joseph S. B. Linde M.D. | 1115 N. Calvert St | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | 12/28/49 | Baltimore Cemetery | Baltimore, Md. |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR AND ADDRESS |
|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | HENRY SANDER & SONS, INC. |

VS 150

BALTIMORE - 13, MD. 482

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81288 G81288

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

175 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Hortense K. Eliasberg

2. DATE OF DEATH: Dec. 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27 20

D. STREET ADDRESS (If rural, give location): 3320 Bancroft Rd

c. Length of stay in Baltimore: Yrs. Mos. Days

5. SEX: female | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH: 7-5-1899 | 9. AGE (In years last birthday): 50 | If Under 1 Year: Months 5 Days 22 | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Moses Kahn | 14. MOTHER'S MAIDEN NAME: Lavina Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: JOHNS HOPKINS HOSPITAL

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinomatosis peritonei DUE TO Carcinoma of ovary — INTERVAL BETWEEN ONSET AND DEATH: 16 months

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION: Dec 1948 | 19B. MAJOR FINDINGS OF OPERATION: Carcinoma of ovary | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/9 19 49 *to* 12/27 19 49, *that I last saw the deceased alive on* 12/27 19 49, *and that death occurred at* 8 30 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: William L. Hartmann M. D. | 23B. ADDRESS: Johns Hopkins Hospital | 23C. DATE SIGNED: Dec 27 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried | 24B. DATE: Dec 29/49 | 24C. NAME OF CEMETERY OR CREMATORY: Balto. Hebrew | 24D. LOCATION (City, town, or county) (State): Belair Rd

DATE RECEIVED BY REGISTRAR: DEC 28 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Harry Goodman Inc. | ADDRESS: 1802 Eastern

VS 150

49a

Please write plainly. Items 1 to 17 must be answered in every case. Physicians: please write the causes of death clearly and legibly. Accuracy in especially important.

G81289

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G81289

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Helen M. Ferry

2. DATE OF DEATH: 12/21/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write IN or RAL and give township): Catonsville 28
D. STREET ADDRESS (If rural, give location): 120 Oak Drive

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | Married | Nov. 13, 1910 | 39 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John F. Farnan | Jesse Bell |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | — | — | Harry Ferry | Same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

a) Acute congestive heart failure — Interval between onset and death: 1 hr.

DUE TO

b) Hypertensive CVD — 4 yrs.

DUE TO

c)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* 12/1/1949 *to* 12/21/1949 *that I last saw the deceased alive on* 12/21/1949 *and that death occurred at* 6 3h a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| H. Est H. Berkus M.D. | St. Agnes Hospital | 12-21-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 29-49 | London Park | Balto Co Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Hunter Williams, M.D. | C. F. Gilbert & Son | 930 Eutaw Pl |

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81280

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G81280

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ALBERT FRAZIER

2. DATE OF DEATH: December 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Balto. General Hosp.

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1119 Briscoe Street 2-1-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Write) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months Days | If under 24 hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Separated | Feb. 10 1901 | 48 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Columbia S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Frazier
14. MOTHER'S MAIDEN NAME: Emma Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Eugene Frazier ADDRESS: 517-W. Fowler St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [ ] NO [X]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH:
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an* Insp. - Inquiry *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* [ ], *suicide* [ ], *homicide* [ ], *undetermined* [ ].

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Buried
24B. DATE: 12-28-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24D. LOCATION (City, town, or county) (State): Cedar Hill, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 26 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: A. Halstead ADDRESS: 918-3 Cedar Hill Ave.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C81291 ✓ 200.1 200.2 C81291

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Edward Tutin, Jr.

2. DATE OF DEATH: Dec. 27, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sinai Hosp.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 711 S. Dallas St. 3-d ✓

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years. If under 1 year, Months, Days, Hours, Min.) |
|---|---|---|---|---|
| M | W | Single | 12/21/1939 | 10 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Student | — | Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Edward Tutin | Genevieve Sobtka |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No None | None | Edward Tutin | Same |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | A. Generalized lymphosarcomatosis | 3 mos. |
| | DUE TO | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | B. | |
| | DUE TO | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Sat. 1949 | Lymphosarcoma of suprasternal lymph node | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month, Day, Year, Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY occur? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Dec. 17, 1949 to Dec. 27, 1949 that I last saw the deceased alive on Dec. 26, 1949, and that death occurred at 7 a.m. from the cause and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Albert J. Weiss M.D. | Sinai Hospital | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City or County) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Holy Roshry | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Willy & Zeiler Inc. | Balto. |

VS 150

55E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C81292

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4 46

C81292

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Catherine M. Gebhardt

2. DATE OF DEATH: 12/22/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2921 E. Pulaski Highway

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore — Md. 6-01
D. STREET ADDRESS (If rural, give location): 2921 E. Pulaski Highway

5. SEX: F.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 4/22/67
9. AGE (In years last birthday): 82 (If under 1 Year: Months / Days; If under 24 hours: Hours / Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Frederick Wagner
14. MOTHER'S MAIDEN NAME: Catherine ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): ✓
(If yes, give war or dates of service): ✓
16. SOCIAL SECURITY NO: ✓
17. INFORMANT: Mrs. F. Gebhardt — ADDRESS: 2921 Pulaski Highway

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 10 YRS.

DUE TO

(B) CHR. INT. NEPH — 5 YRS.

DUE TO

(C) UREMIA — 6 WKS.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 17, 1949, to Dec 22, 1949, *that I last saw the deceased alive on* Dec 22, 1949, *and that death occurred at* 8 P.M., *from the causes and on the date stated above.*

23A. SIGNATURE: James F. Kavanagh M.D. M.D.
23B. ADDRESS: 3017 W. Fayette St.
23C. DATE SIGNED: 12-24-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/26/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Selby & Sidon — ADDRESS: 403 S. Wolfe St.

VS 150

1-31a

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81293

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81293

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES OLIVER THORNE

2. DATE OF DEATH: 27 DECEMBER 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3620 Roland Ave.

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3620 Roland Ave. 13-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | June 28, 1876 | 73 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Elevator Operator (rtd) | Crown Cork & Seal | Co Balto., Md. | |

13. FATHER'S NAME: Aaron H. Thorne

14. MOTHER'S MAIDEN NAME: Emma L. Lippincott

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 216-10-7616 | Mrs. Mary C. Thorne | 3620 Roland Ave. |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Carcinoma, rectum | 18 months |
| | DUE TO (B) & multiple metastases | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| October 1948 | (Biopsy) Carcinoma, inoperable | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1948 *to* 27 Dec 1949 *that I last saw the deceased alive on* 27 Dec 1949 *and that death occurred at* 12:30 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | 2020 N Charles St | 27 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/30/1949 | Mt. Zion Cem. | Freeland, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | [signature] Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46D

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81294

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

241

G81294

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): George W. Hagert

2. DATE OF DEATH: 12/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 16 N. Decker Ave
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore MD
D. STREET ADDRESS (If rural, give location): 6 N. Decker Ave 6 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | M. | Feb. 9-1888 | 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Paint man | Not Dist to | Baltimore | |

13. FATHER'S NAME: John W.

14. MOTHER'S MAIDEN NAME: Anna Smith

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT / ADDRESS |
|---|---|---|
| | | Gertrude Hagert 16 N Decker ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocardial Degeneration — DUE TO

(B) Bronchial Asthma — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. L. Schumbe M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: 12/28/49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/30/49 | Baltimore | Mt Olive + Rose St |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Clarence F. Hoffman | 1639 Boundary |

VS 151

937

G81295

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E894.3 G81295 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JAMES CARTER — N-969

2. DATE OF DEATH December 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 1503 Aisquith Street 9-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | colored | Married | Sept 18, 1915 | 34 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Royster Chemical Co. | Bald Md | |

13. FATHER'S NAME unknown

14. MOTHER'S MAIDEN NAME unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Pearl Carter | 1503 Aisquith St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) membranous tracheobronchitis and bronchopneumonia due to inhalation of chemical fumes (ammonia)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | fertilizer factory | F.S.Guano Royster Co. Fairfield, Md. 25/6 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 21, 1949 1.15am. | WHILE AT WORK [X] NOT WHILE AT WORK [ ] | Deceased was transferring liquid (over) |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*
(Autopsy, Inspection or Inquiry)

23A. SIGNATURE R S Fraher M.D.
23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ]
23C. DATE SIGNED Dec. 26, 1949

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 29/49 | Mt. Calvary Cem. | A.A. County Md |

DATE RECEIVED BY LOCAL REGISTRAR DEC 28 1949
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR Mrs Robert G. Elliott Daughter
ADDRESS 1129 W. Cantin St.

VS 151

179 x

G81296

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81296 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Roy Morgan (ASA MORIAN)

2. DATE OF DEATH: December 24, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1750 E. Preston St. 8-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | July 3, 1889 | 60 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Huckster | | Prince Edward Co., Va. | U.S.A. |

13. FATHER'S NAME: Jack Morgan

14. MOTHER'S MAIDEN NAME: Betty Holmes

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Geo. Holmes | 1750 Preston St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

(B)

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Carl L Royer M.D. | | 25 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 28/49 | Int. Calvary Cem. | G. A. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Funeraltor Williams, M.D. | Mrs Robert A. Elliott & Daughter | 1129 N. Carrollton Av. |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81297

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 446 Registered No.

G81297

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY B. DURKIN

2 DATE OF DEATH 12/26/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 427 N. Highland ave.

c Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write 10 RAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 26-44 427 N. Highland ave.

| 5 SEX | 6 COLOR OR RACE | 7 SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8 DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | white | Widowed | 10/ J 1894 | 55 | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Baltimore, Maryland | U.S.A. |

| 13. FATHER S NAME | 14 MOTHER S MAIDEN NA |
|---|---|
| Patrick F. Bradley | Dora Nolan |

| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT ADDRESS |
|---|---|---|
| no | none | Mrs. Robert Kansler 427 N. Highland ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) ARTERIOSCLEROSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 YRS

DUE TO

(B) CHR. INT. NEPHRITIS — 5 YRS

DUE TO

(C) EMBOLISM R ARM. — 7 MO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg. etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June, 1942, *to* Dec 26, 1949, *that I last saw the deceased alive on* Dec 26, 1949, *and that death occurred at* 5. A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C DATE SIGNED |
|---|---|---|
| James F Kavanaugh M D M. D. | 3014 Mt Federal St | 12-28-49 |

| 24A BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, Town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 29/49 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Ellington Williams, M.D. | Chas J Evans & Son Inc | 118 W. Mt. Royal ave. |

VS 150

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81298

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 ✓ G81298 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Jannie Smith

2. DATE OF DEATH: 12/24/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto. City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I206 Short Court Apt.A-2

D. STREET ADDRESS (If rural, give location): I206 Short Court Apt.A-2 X 5-01

c. Length of stay in Baltimore: 6 Yrs. (Yrs. / Mon. / Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Widow | 1/30/1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Clayton N.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Unkown | Alice Parridge |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Eva Cash | I206 Short Court Apt.A-2 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Uremia — DUE TO — (INTERVAL BETWEEN ONSET AND DEATH) 3 mos.

(B) Hypertensive C-V Renal Disease (?) — DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 6/24 *19*49 *to* 12/24 *, 19 __, that I last saw the deceased alive on* 12/14 *, 19*49*, and that death occurred at* 9:15 *A.M., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Louis Grant M.D. | 601 N. Carrollton | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/28/1949 | Bunker Hill Cemetery | Clayton N.C. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Brantly Avenue |

VS 150

131a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81299

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

44 Registered No. G81299

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Rebecca Cummings

2. DATE OF DEATH: 12/25 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 21 South Duncan Street
c. Length of stay in Baltimore Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 21 South Duncan Street 1-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col. | Sep. | 2/14/1905 | 44 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore Maryland | U.S.A. |

13. FATHER'S NAME: Unkown

14. MOTHER'S MAIDEN NAME: Martha Robinson

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Mable Cole | 36 South Caroline St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Cardio vascular Syphilis

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-15, 1949 *to* 12-25, 1949, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 8:30 P.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. C. Burrell M. D. | 1V1 Aisquith St | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/1949 | Mt Calvery Cemetary | Brooklyn A.A.Co.Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Brantly Ave. |

VS 150

1313

AB-119835

681300

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 681300 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Anna Erdman

2. DATE OF DEATH 12-25-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Baltimore

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Baltimore County

c. Length of stay in Baltimore Life Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 846 Oakleigh Beach Road

| 5. SEX | 6. COLOR or RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year Months Days | If under 24 hours Hours Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | May 25- 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at Home | Maryland | |

13. FATHER'S NAME ? Nickols

14. MOTHER'S MAIDEN NAME Unk

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| | | | Baltimore City Hospitals Records: 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchopneumonia | |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Hypertensive Cardiovascular Disease | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May 20- 1948 *to* Dec. 25- 1949, *that I last saw the deceased alive on* Dec. 25- 1949, *and that death occurred at* 6.15 PM *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Cogan M.D. | Baltimore City Hospitals | 12-25-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 12-28-49 | Mt Carmel | Woodlawn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25A. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, Jr | John S. Kennedy | 448 Eastern Ave |

VS 150

93D Balto 21 Md

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81301 BALTIMORE CITY HEALTH DEPARTMENT 450.0 G81301

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): JENNIE ROTHSTEIN
2. DATE OF DEATH: 12-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Levindale Home
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-38
D. STREET ADDRESS (If rural, give location): 3022 Garrison Blvd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | white | married | 1897 | 52 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Saleswoman, Hdkf | Dept Store | Baltimore, Md. | U S A. |

13. FATHER'S NAME: Solomon Salzberg
14. MOTHER'S MAIDEN NAME: Rose ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 213-12-5870
17. INFORMANT: Benjamin Rothstein ADDRESS: 3022 Garrison Blvd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Pulmonary infarction | half hour |
| DUE TO (B) | arteriosclerosis | years |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Nephrosis. | 3 weeks |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 10-6, 1949 *to* 12-27, 1949 *that I last saw the deceased alive on* 12-27, 1949 *and that death occurred at* 3:12 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry Magel M. D. | Levindale Home | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-29-49 | Bals Hebrew Cemetery | Baltimore, Maryland |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949
REGISTRAR: Washington Williams, M.D.
25. FUNERAL DIRECTOR: Sol. Levinson & Bros. ADDRESS: 1126 W. North Avenue

VS 150

1111a

G81302

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81302 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) STEPHANIE Schach

2. DATE OF DEATH December 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1138 N. Longwood ST

c. Length of stay in Baltimore 77 Yrs. Mos. Days.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE 20-05
D STREET ADDRESS (If rural, give location) 2118 Wilkens Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | February 12 1862 | 87 | — | — | — | — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Milliner | Own business | Germany | U.S.A. |

13. FATHER'S NAME Karl Schach

14 MOTHER'S MAIDEN NAME Ida Isley

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|---|
| no. | no. | none. | Oscar Schach | 1138 N. Longwood |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Myocarditis

DUE TO And Myocardial Degeneration

INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility without dementia

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* September, 1946 *to* Dec. 26, 1949, *that I last saw the deceased alive on* Dec 26, 1949, *and that death occurred at* 5.05 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C DATE SIGNED |
|---|---|---|
| Melvin N. Borden M. D. | 2030 W. Fayette St | 12/26/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial. | Dec. 29-1949. | London Park Cemetery | Baltimore - Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Hampton Williams, M.D. | Charles J. Schwab, | 3512 Fredk. Ave. |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

937

G81303 BALTIMORE CITY HEALTH DEPARTMENT G81303

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MINNIE HUNTER
2. DATE OF DEATH: DEC. 26, 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1102 McKEAN AVE
C. Length of stay in Baltimore: 5 years (Yrs. Mos. Days)
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 16 04
D. STREET ADDRESS (If rural, give location): 1102 McKEAN AVE
5. SEX: F
6. COLOR OR RACE: COLORED
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: 8-28-1889
9. AGE (In years last birthday): 60 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): SUMMETON. S.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: HENRY SAMPSON
14. MOTHER'S MAIDEN NAME: MARY BRIGGS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: MOSES. HUNTER. ADDRESS: 1102 McKEAN AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Potts disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐
21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25, 1949 *to* 12-26, 1949, *that I last saw the deceased alive on* 12-24, 1949, *and that death occurred at* 8:00 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: C. R. Campbell M. D
23B. ADDRESS: 718 Dolphin St
23C. DATE SIGNED: 12-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-31-49
24C. NAME OF CEMETERY OR CREMATORY: JUNK YARD
24D. LOCATION (City, town, or county) (State): FORESTON S.C.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949
REGISTRAR'S SIGNATURE: Washington Williams, M.D
25. FUNERAL DIRECTOR: William A. Cackson ADDRESS: 916 Ponca ave

16

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81304

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81304

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): George Wesley Britton

2. DATE OF DEATH: 12-23-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1213 Wilmer Court

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 1213 Wilmer Court

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | Col. | Widow | Aug. 4 1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Harford Co. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jacob H. Britton | Martha ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No. | | | Mabel Britton | Wilmer Ct |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Cerebral Hemorrhage | 2 days |
| DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Malignant Hypertension | 1 yr. |
| DUE TO | | |
| | (C) Generalized Arteriosclerosis | - |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Nov 5 1949 *to* Dec 23, 1949, *that I last saw the deceased alive on* Dec 23, 1949, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | 1432 Penna. Ave | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-28-1949 | W.F. Auburn Cem. | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Mrs Katie R Williams | 322 N Schroeder St |

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

C81305 | BALTIMORE CITY HEALTH DEPARTMENT | C81305

# CERTIFICATE OF DEATH

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Goldie Legolder Murray Parrott
2. DATE OF DEATH: 12-24-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 21 N. Schroeder St
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto.
D. STREET ADDRESS (If rural, give location): 21 N. Schroeder St. 18 C1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Married | May 4 1886 | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Darlington S.C. | U.S.A. |

13. FATHER'S NAME: Henry Mixon
14. MOTHER'S MAIDEN NAME: Hannah ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Adell Brown | 724 N. Saratoga St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardiac Neurosclerosis Asthenia Lyon — (Interval between onset and death)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April 15, 1949 *to* Dec 24, 1949 *that I last saw the deceased alive on* Dec 24, 1949 *and that death occurred at* 4 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wilson H. Welch M.D. | 515 Walker Ave | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-28-1949 | Mt Zion Cem. | Lansdowne Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Hunter Williams, M.D. | Mrs Ketie R Williams | 3221 Woodland |

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G81306 G8T306

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): HIMBERG, ERIK RAVEN

2. DATE OF DEATH: Dec. 22, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U S Marine Hospital, Baltimore 11, Maryland

c. Length of stay in Baltimore: ? (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New York
D. STREET ADDRESS (If rural, give location): 33 1st Place, Brooklyn, New York

5. SEX: M

6. COLOR or RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Nov.21, 1919

9. AGE (In years last birthday): 29 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AB Seaman

10B. KIND OF BUSINESS OR INDUSTRY: Seafaring

11. BIRTHPLACE (State or foreign country): Norway

12. CITIZEN OF WHAT COUNTRY? Norway

13. FATHER'S NAME: Mangus Himberg

14. MOTHER'S MAIDEN NAME: Sophie Himberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 124-18-5465

17. INFORMANT: Records-U.S.Marine Hospital, Baltimore 11, Md. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Seminoma of testicle (resected 4/7/49) massive metastasis to liver | 1 yr. |
| ANTECEDENT CAUSES | DUE TO | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | Hemoperitoneum | Recent |
| | DUE TO | Hemorrhagic pleural effusion | |
| | (C) | Hypostatic pneumonia, left and | Recent |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | right lower lobes | |

19A. DATE OF OPERATION: 4/7/49

19B. MAJOR FINDINGS OF OPERATION: Seminoma of testicle and cord

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 19, 1949 *to* 22 Dec., 1949, *that I last saw the deceased alive on* 22 Dec., 1949 *and that death occurred at* 6:30 P.m., *from the causes and on the date stated above.*

23A. SIGNATURE: John L. Wilson
John L. Wilson, Medical Director M. D.

23B. ADDRESS: US Marine Hospital, Balto, Md.

23C. DATE SIGNED: 12/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24B. DATE: 12/24/49

24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949

REGISTRAR'S SIGNATURE: Thurston Williams, M.D.

25. FUNERAL DIRECTOR: Lilly & Zuler, Inc. (ADDRESS) 403 S. Wolfe St.

VS 150

51C

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81307

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81307

BIRTH NO.

Registered No.

1. NAME OF DECEASED (Type or Print): MARY E. LINK

2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 3810 Third Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3810 Third Street 25-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | 3/31/1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housework | Home | Ohio | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Adam Goss | Annie Henderson |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Family - Same | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage
DUE TO
(B) Hypertensive Cardiovascular disease
DUE TO
(C) Nephritis Retinitis Blindness.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* June 15, 1948 *to* Dec 27, 1949 *that I last saw the deceased alive on* 12/27/1949 *and that death occurred at* 9.15 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Ruben M. D. | 203 Patapsco ave | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| B | 12/30/49 | Cedar Hill | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | Jas. L. McCully | 130 E. Fort Ave. |

VS 150

131a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BS G81308 ✓ G81308

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

Registered No. 42,201

BIRTH NO.

1. NAME OF DECEASED (Type or Print): James Halligan

2. DATE OF DEATH: 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
C. Length of stay in Baltimore: Since 1909 (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): B.C.H. (No Home)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | 1871 | 78? | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Ireland | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Records*Balto. City Hospitals | 4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Arteriosclerotic Vascular Heart Disease | |
| ANTECEDENT CAUSES | DUE TO (B) | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 4-28, 19 19 *to* 12-18, 19 49, *that I last saw the deceased alive on* 12-18, 19 49, *and that death occurred at* 1:15 P.M. *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| P. B. Logan M.D. | 4940 Eastern Avenue | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, or county) (State) |
|---|---|---|---|
| Burial | 12/22/49 | Sacred Heart | German Hill Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1949 | Huntington Williams, M.D. | J. J. Tahey & Sons | 937 |

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81309 ✓ G81309

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 33

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): MARY LEFKOT

2. DATE OF DEATH: 12/28/99

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): South Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1727 Patapsco Street 23-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 2/25 [illegible] | 63 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Baltimore Md. | |

13. FATHER'S NAME: John Ross

14. MOTHER'S MAIDEN NAME: Elizabeth

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Bronchopneumonia | 2 da |
| DUE TO (B) | Cerebral Thrombosis | 3 da |
| DUE TO (C) | Arteriosclerosis | |

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/26/99 *to* 12/28/99, 19__, *that I last saw the deceased alive on* 12/27/99, 19__, *and that death occurred at* 9:35 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 1213 Eight St | 12/28/99 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 30/99 | Holy Cross | 114 & 11th Aves |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 28 1999 | Huntington Williams, M.D. | Morton J. Cooper | |

VS 150

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

836

AB-234507 G81310 G81310

# BALTIMORE CITY HEALTH DEPARTMENT
## CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print): Antonie Pauline Loos

2. DATE OF DEATH: 12-27-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

c. Length of stay in Baltimore: 62yrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1724 N. Montford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Aug. 7- 1869 | 80 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AT HOME | | Germany | |

13. FATHER'S NAME: Unknown (Dec.

14. MOTHER'S MAIDEN NAME: Unknown (Dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S NAME AND ADDRESS: Baltimore City Hospitals Records: 4940 Eastern Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27- , 1949 *to* 12-27- , 1949 *that I last saw the deceased alive on* 12-27- , 1949 *and that death occurred at* 11PM *, from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D. | 23B. ADDRESS: Baltimore City Hospitals | 23C. DATE SIGNED: 12-28-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | Dec 30-49 | Baltimore | Dec 30-49 - Balto Md - |

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949

REGISTRAR'S SIGNATURE: [signature] Lucington Williams, M.D.

25. FUNERAL DIRECTOR: Ellsworth Funeral Home | ADDRESS: 94a 5118 Gwynn Oak Ave

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81311 G81311

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 60.0

BIRTH NO. 49-28484 Registered No.

1. NAME OF DECEASED (Type or Print): Gloria Lee Kircher (Newborn)

2. DATE OF DEATH: 12-27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Balto General Hosp
c. Length of stay in Baltimore: 28 hrs 50 min (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 6
D. STREET ADDRESS (If rural, give location): 3914 White Ave 27-34

5. SEX: Female
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: 12-26-49
9. AGE (In years last birthday): Under 1 Year — Months: — Days: 1 — Hours: 4 — Min.: 50
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Henry Kircher
14. MOTHER'S MAIDEN NAME: Mary Agnes Beatty
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother
ADDRESS: Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemorrhage
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 28 hr 50 min

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES X NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-26, 1949, to 12-27, 1949, that I last saw the deceased alive on 12-27, 1949, and that death occurred at 6:20 A m., from the causes and on the date stated above.

23A. SIGNATURE: James L. Gray, M. D.
23B. ADDRESS: West Balto. General Hosp.
23C. DATE SIGNED: 12-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/29/49
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Eastern Ave

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949
REGISTRAR'S SIGNATURE: Carrington Williams, M.D.
25. FUNERAL DIRECTOR: Earl B. Wolverton
ADDRESS:

160a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81312

BALTIMORE CITY HEALTH DEPARTMENT V 331 G81312 Registered No.

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 230 W. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 W. Biddle St. 11-04
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Rosetta Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

| 4. Sex | 5. Color or race | 6 (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Single |

6 (b) Name of husband or wife ---------

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Oct. 15, 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 Yrs. | | | hr. min. |

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housekeeper -Home

11. Industry or business

FATHER
12. Name Thomas H. Smith
13. Birthplace Baltimor e Maryland

MOTHER
14. Maiden Name Rebecca -- --
15. Birthplace Baltimore, Maryland

16 (a) Informant Clarence E. Smith
(b) Address 230 W. Biddle St.

17 (a) Burial (b) Date thereof Dec. 31-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Maryland

18 (a) Funeral director George T. A. Gibson Sr.
(b) Address 1735 Druid Hill Ave.

19 (a) (b) Huntington Williams, M.D. Registrar
(Signature of local registrar)
DEC 28 1949

VS 150

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** December 27 19 49 at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Dec 19 49 to 27 Dec 19 49 and that I last saw h-- alive on Dec 27 19 49.

Immediate cause of death Hypertensive Cerebral Thrombosis — Duration 2 years or more

Due to Arteriosclerosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj. M. Baker Jr. M. D.
Address 9 E. Chase St. Date signed 28-Dec 49

82a

G81313

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. G81313 Registered No. 4120

1. NAME OF DECEASED (Type or Print) Minnie G. Kirkpatrick

2. DATE OF DEATH Dec 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4101 Gatelaw Road

c. Length of stay in Baltimore: Yrs. 65 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md. B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4101 Gatelaw Road 15-10

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov 28 1874 | 9. AGE (In years last birthday) 75 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | 10B. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (State or foreign country) Baltimore Md. | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George W. Horseman | 14. MOTHER'S MAIDEN NAME Joanna Townsend Joanna Townsend

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Miss Louise Kirkpatrick | ADDRESS 4101 Gatelaw Road

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: about 2 days
DUE TO
(B) Cardiovascular disease — about 5 yrs.
DUE TO
(C) Cerebral hemorrhage + paralysis — about 6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION — | 19B. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) — | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) — | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 9, 1949 to Dec. 27, 1949 that I last saw the deceased alive on Dec 26 1949, and that death occurred at 10 a m., from the causes and on the date stated above.

23A. SIGNATURE Charles Kirkpatrick M. D. | 23B. ADDRESS 2220 Harrison Blvd. | 23C. DATE SIGNED Dec 27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Dec 29 1949 | 24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cem | 24D. LOCATION (City, town, or county) Balto Co. Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 28 1949 | REGISTRAR'S SIGNATURE Washington Williams, M.D. | 25. FUNERAL DIRECTOR J. Willis Lamotte | ADDRESS 4510 Liberty Hgts Ave

VS 150

937

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr E. J. Alessi

G81314

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 174

G81314
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Sapia

2 DATE OF DEATH: Dec 27-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2813 Chesley Ave

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2813 Chesley Ave 27-49

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | April 8-1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| at Home | | Italy | |

13. FATHER'S NAME: Joseph Onorato

14. MOTHER'S MAIDEN NAME: Josephine Cortina

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Joseph Sapia ADDRESS: 2813 Chesley

## MEDICAL CERTIFICATION

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO

(B) Leiosarcoma of uterus — 1 yr.

DUE TO

(C) Metastases to liver — 6 mos

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION: January 6 August 1949

19B. MAJOR FINDINGS OF OPERATION: Leiosarcoma of uterus and single metastases to liver

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 4, 1943 to Dec. 27, 1949 that I last saw the deceased alive on Dec. 27, 1949, and that death occurred at 7.30A m., from the causes and on the date stated above.

23A. SIGNATURE: Salerno M.D.

23B. ADDRESS: 6217 Harford Rd

23C. DATE SIGNED: 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-30-49

24C. NAME OF CEMETERY OR CREMATORY: New Cathedral

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 28 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Leonard J. Ruck ADDRESS: 5305 Harford

48B

G81315

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81315

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH RICHARD O'BRIEN

2. DATE OF DEATH Dec 27, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hosp.

C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Balto 26-06

C. Length of stay in Baltimore Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location) 6540 St. Helen Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Sept 7, 1888 | 61 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | B.&O.R.R. | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph R O'Brien | Mary M O'Brien |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WWI | | Loula M O'Brien | 6540 St Helen Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary occlusion and myocardial infarction

DUE TO

(B) with cardiac Tamponade

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/24/49 19 , to 12/27 , 1949, that I last saw the deceased alive on 12/27, 1949 and that death occurred at 6 35 m., from the causes and on the date stated above.

23A. SIGNATURE Thaddeus Suwinski M. D. | 23B. ADDRESS St. Joseph's Hosp | 23C. DATE SIGNED 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/30/49 | 24C. NAME OF CEMETERY OR CREMATORY National | 24D. LOCATION (City, town, or county) Baltimore (State) Md

DATE RECEIVED BY LOCAL REGISTRAR DEC 29 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR Tallom & Son Inc | ADDRESS 1219 E Pratt St

DEC 29 1949

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81316

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G81316

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emma May Ritz

2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3203 White Ave

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 12-04
D. STREET ADDRESS (If rural, give location): 319 E. 22nd St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If less than 1 day, hours or minutes) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | about 1868 | about 81 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Saleslady | Hab Dept Store | Balto. Co. Md. | |

13. FATHER'S NAME: George H. Ritz

14. MOTHER'S MAIDEN NAME: Georgianna Lapp

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Raymond C Ritz | 3203 White Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: unkn

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO Hypertension — unkn

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Oct 3, 1949 *to* Dec 27, 1949 *that I last saw the deceased alive on* Dec 27, 1949 *and that death occurred at* 8:49 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. Rahsdam M. D. | 117 W. 25th St. | Dec. 28, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/30/49 | Woodlawn | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | Wm Cook Inc | 127 St Paul St. |

VS 150

94a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81317

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G81317

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY ANNA STERNER

2. DATE OF DEATH: DEC. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2109 DUKELAND ST.
C. Length of stay in Baltimore: 26 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTO., MD.
D. STREET ADDRESS (If rural, give location): SAME 15-47

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | If Under 1 Year: Days | If Under 24 Hours: Hours | If Under 24 Hours: Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | M | MAY 12, 1896 | 53 | 7 | 18 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | PA. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| HARVEY SMITH | NORA FELIX |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | RUSSEL STERNER (HUSB) | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebro-vascular accident
DUE TO
(B) Hypertension
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | 0 | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| 0 | 0 | 0 |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 0 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 0 |

22. *I hereby certify that I attended the deceased from* Dec. 28 1949 *to* ——— 19— *that I last saw the deceased alive on* Dec. 28 1949 *and that death occurred at* 4:45 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Marvin Goldstein M. D. | 5334 Liberty Heights Ave. | Dec. 28, '49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Gettysburg | Gettysburg Pa |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | Wilbur Cook | 1214 E. Fayette St |

VS 150

83a

G81318

BIRTH NO. 49-26777

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

51

G81318

Registered No.

1. NAME OF DECEASED (Type or Print): Baby Szuchmuchi

2. DATE OF DEATH: Dec 21, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto 24-ov
D. STREET ADDRESS (If rural, give location): 1223 Riverside ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY Hosp.

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | newborn | 12/11/49 | 11 days | | 26 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): U.S.A. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: alexander

14. MOTHER'S MAIDEN NAME: audrey duvall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY #:NO

17. INFORMANT: J ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) respiratory failure
DUE TO congenital Compression of medulla & cerebellum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)
DUE TO congenital spina bifida & meningomyelocele

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: atrophy L kt. kidney, hydronephrosis & cystitis

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 17, 1949 *to* Dec 21, 1949, *that I last saw the deceased alive on* Dec 21, 1949, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Burton V Lockwood M. D.

23B. ADDRESS: Mercy Hosp

23C. DATE SIGNED: Dec

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/29/49

24C. NAME OF CEMETERY OR CREMATORY: Holy Cross

24D. LOCATION (City, town, or county) (State): Ritchie Highway

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949

REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.

25. FUNERAL DIRECTOR: John F. Denny, Inc. ADDRESS: 715 Light St -30

VS 150

1576

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81319

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163.5

G81319 Registered No.

BIRTH NO. 49-27996

1. NAME OF DECEASED (Type or Print): Baby Stanton

2. DATE OF DEATH: Dec. 26, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D. STREET ADDRESS (If rural, give location): 2807 Booker Dr

5. SEX: F

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S.

8. DATE OF BIRTH: 12-22-49

9. AGE (In years last birthday): If under 1 Year: Months: Days: 4 — If under 1 Day: Hours: Min.:

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wilson Stanton

14. MOTHER'S MAIDEN NAME: Idella Fowlks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Kernicterus

DUE TO

ANTECEDENT CAUSES

(B) Aspiration pneumonia

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Prematurity

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/22, 1949 *to* 12/26, 1949, *that I last saw the deceased alive on* 12/26, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: Harrison Clark Spencer M. D.

23B. ADDRESS:

23C. DATE SIGNED: 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Hosp Disposal

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY:

24D. LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949

REGISTRAR'S SIGNATURE: Christopher Williams, M.D.

25. FUNERAL DIRECTOR: ADDRESS:

VS 15 Hospital Disposal

159

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81320

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

760.5 Registered No. G81320

BIRTH NO. 49-27998

1. NAME OF DECEASED (Type or Print): Baby "Boy" Williams

2. DATE OF DEATH: DEC 23 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. 2 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Township
D. STREET ADDRESS (If rural, give location): 126 Willow Ct (22)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | | 12-21-49 | | | 2 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md | |

13. FATHER'S NAME: Lewis Williams

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Intra-cranial hemorrhage

DUE TO

(B) Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-21 1949 *to* 12-23 1949 *that I last saw the deceased alive on* 12-23 1949 *and that death occurred at* 5:40 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harrison Clark Spencer M. D. | | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Hoy Burial | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | |

VS 150

160a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C81321

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

C81321

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Minnie Nelson

2. DATE OF DEATH: December 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1905 W. North Ave.

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Married | 3-29-[illegible] | 41 5/12 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Va | |

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Subarachnoid hemorrhage

DUE TO

(B) Aneurysm of middle cerebral a.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 12-11, 1949 *to* 12-27, 1949, *that I last saw the deceased alive on* 12-27, 1949, *and that death occurred at* 5:30 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter Arons M. D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-29-49 | arlington | md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, Jr. | George S. Nelson | 1303 Pressman st |

VS 150

96

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81322

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No. G81322

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 1007 Warden Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md. (b) County 10-01
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Warden Av.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ethel B. Langston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19 1867

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired. (Housewife)

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Anna Knight.

(b) Address 1340 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-49 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Frederick Road

18 (a) Funeral director Albert L. Veith Jr.

(b) Address 1606 N. Chester Street

19 (a) DEC 29 1949 (Date rec'd by registrar) Livingston Williams Registrar

(b) 6

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 19 49 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..... to 19....., and that I last saw h alive on 19.....

Immediate cause of death: Cerebro vascular accident — Duration ?

Due to Hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. MacMurchy M.D.

Address 801 Barea Bldg. Date signed 12/29/49

VS 159

937

G81323

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

No. 1

G81323

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Bessie N. Moran

2. DATE OF DEATH 12/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
West Balto. General Hosp

C. Length of stay in Baltimore 67-- Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 106 Woodlawn Road 27-14

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | S | Apr. 28, 1882 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clerk | B.& O. R.R. | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charles S. Moran | Theodosia Ridgeway |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 705-03-7499 | Charles Moran | 4429 Clifton Rd., |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Coronary artery disease

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 18, 1949, *to* Dec 28, 1949, *that I last saw the deceased alive on* Dec. 28, 1949, *and that death occurred at* 9:25 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Barbara Y. Bishop M. D. | West Balto. Gen. Hosp. | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-31-49 | Loudon Park | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, Jr. | G. Howard Strong | 3207 W. North Ave., |

VS 150

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81324

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

31 Registered No. G81324

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MARY SHANE

2. DATE OF DEATH: 12-28-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 27-6
D. STREET ADDRESS (If rural, give location): 2914 Edgecourt Circle

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2919 Edgecomb Circle

c. Length of stay in Baltimore: 53 Yrs. [illegible] Days

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 68 | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Levine
14. MOTHER'S MAIDEN NAME: Chipa

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Philip Shane ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO
(B) Cerebral Arteriosclerosis — 6 Months
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Jan 19[illegible] *to* Dec 28 19 49 *that I last saw the deceased alive on* 12 Dec 19 49 *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 2402 Eutaw Place
23C. DATE SIGNED: 12 Dec 29

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-29-49
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Herring Run
24D. LOCATION (City, town, or county) (State): Dalto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Jack Levin Inc ADDRESS: 2100 Eutaw Pl

VS 150

83a

G81325

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81325

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Louis BERMAN

2. DATE OF DEATH: 12-27-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A. STATE Md; B. COUNTY; C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-04; D. STREET ADDRESS (If rural, give location) 811 Brooks Lane

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 811 Brooks Lane

c. Length of stay in Baltimore: 50 Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) | If under 1 Year: Months Days | If under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | | 76 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Merchant | Luggage | Russia | |

13. FATHER'S NAME: Israel

14. MOTHER'S MAIDEN NAME: Leah

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Rose Sermon | ADDRESS: 811 Brooks Lane |
|---|---|---|---|

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial insufficiency — Interval between onset and death: 4 years

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arterio sclerosis — Interval between onset and death: 14 years

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-22 *to* 12-27, 19 49 *that I last saw the deceased alive on* 12-27, 19 49 *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Weitbrecht M.D. | [illegible] | Dec. 28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-29-49 | Bnai Israel | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Cuntis for Williams, M.D. | Jack Lewis Inc | 2109 Eutaw Pl. |

VS 150

927

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81326 CERTIFICATE CORRECTED 11-16-[illegible] BALTIMORE CITY HEALTH DEPARTMENT G81326

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): David Cohen | 2. DATE OF DEATH: Dec. 28, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Seton Institute<br>c. Length of stay in Baltimore: Yrs. Mos. Days | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A STATE: Maryland B COUNTY<br>C CITY OR TOWN (If outside corporate limits, write RURAL, and give township)<br>D STREET ADDRESS (If rural, give location) |
| 5. SEX: M<br>6. COLOR OR RACE: W<br>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married | 8. DATE OF BIRTH<br>9. AGE (In years last birthday): 5<br>If under 1 year: Months, Days<br>If under 24 hours: Hours, Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student<br>10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): [illegible]<br>12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME: Louis Cohen | 14. MOTHER'S MAIDEN NAME: Rachel [illegible] |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no<br>(If yes, give war or dates of service)<br>16. SOCIAL SECURITY NO | 17. INFORMANT: [illegible] W. Rogers Ave. ADDRESS |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Asphyxia [illegible] | |
| | DUE TO | |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Hospital | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Seton Institute Reisterstown Rd. |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 28, 1949 PM | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? [illegible] |

22. *I certify that I took charge of the remains described above, held an* Insp. & In. *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*
(Autopsy, Inspection or Inquiry)

| | | |
|---|---|---|
| 23A. SIGNATURE: R S Fisher M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED: Dec 29 1949 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B. DATE: 12-30-49 | 24C. NAME OF CEMETERY OR CREMATORY: Beth Tefiloh |
| 24D. LOCATION (City, town, or county) (State): Balto Md | | |
| DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949 | REGISTRAR'S SIGNATURE: Huntington Williams, M.D. | 25. FUNERAL DIRECTOR: Jack Lewis Inc. ADDRESS: 2100 Eastern Ave |

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

164a

G81327

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81327

BIRTH NO. ____ Registered No. ____

1. NAME OF DECEASED (Type or Print): Georgie M. Haslup

2. DATE OF DEATH: 12-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2633 E. Preston St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. ____ Mos. ____ Days ____

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 8-03
D. STREET ADDRESS (If rural, give location): 2633 East Preston St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | Single | 4-7-1892 | 57 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tel. Operator
10B. KIND OF BUSINESS OR INDUSTRY: Bal. Electric Co
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: George R. Haslup
14. MOTHER'S MAIDEN NAME: Sophie M. Bendler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or Unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO: 21-265-6210
17. INFORMANT: Geo. R. Haslup ADDRESS: 2633 E. Preston St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
(B) Carcinoma Uterus — 2 yrs.
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 4 1946 to Dec 26, 1949 that I last saw the deceased alive on Dec 26, 1949 and that death occurred at 11 45 P m., from the causes and on the date stated above.

23A. SIGNATURE: Harry H. Cohn M.D.
23B. ADDRESS: 2607 Harlan
23C. DATE SIGNED: Dec 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-29-49
24C. NAME OF CEMETERY OR CREMATORY: Parkwood Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John C. Miller Inc. ADDRESS: 2435 E. Oliver St

480

VS 150

G81328

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Reg. 1

G81328

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary A. Fleisbell

2. DATE OF DEATH: Dec. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 514 N. Castle St.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 514 N. Castle St.

7-0J

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Jan. 10, 1865 | 84 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John A. Fleisbell | Susanna Hutton |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| No. | | Miss Nellie Fleisbell 514 N. Castle St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | 5 yrs |
| DUE TO (B) | Chronic Nephritis | 4 yrs. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | General Arteriosclerosis | 6 yrs |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* April, 1949 *to* Dec 27, 1949 *that I last saw the deceased alive on* Dec 27, 1949 *and that death occurred at* 2A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Francis J. Ayd M. D. | 2005 E. Monument St | Dec 28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 31, 1949 | New Cathedral | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR / ADDRESS |
|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | Ullrich Funeral Home 2008 Orleans St. |

VS 150

121a

G81329

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81329

1. NAME OF DECEASED (Type or Print): Alice T Sweeney

2. DATE OF DEATH: Dec 28-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland 2653 Edmondson Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: 34 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto Md
D. STREET ADDRESS (If rural, give location): 2653 Edmondson Ave 20 Ct

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug 6-1872
9. AGE (In years last birthday): 77
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY: House wife
11. BIRTHPLACE (State or foreign country): Balto Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jacob W Bratzel
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: ow
17. INFORMANT: Mrs Ruth Davis ADDRESS: 2650 Edmondson Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerosis
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Senility

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15, 1949 *to* Dec. 28, 1949, *that I last saw the deceased alive on* Dec. 27, 1949, *and that death occurred at* 8:40 A m., *from the causes and on the date stated above.*

23A. SIGNATURE: DCuac Laughlin M. D.
23B. ADDRESS: 4508 Edmondson Village
23C. DATE SIGNED: 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE: Dec 31/49
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Chas P Towell ADDRESS: 3727 Edmondson Ave

VS 150

437

G81330
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81330

E890.0
E928.0 (1)

1. NAME OF DECEASED (Type or Print): PETER J. (SKEUHR) SKUHR
2. DATE OF DEATH: December 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Anne Arundel
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Long Point
D. STREET ADDRESS (If rural, give location):

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 4, 18[illegible]
9. AGE (In years last birthday): 66 (Jan)
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles H. Skuhr
14. MOTHER'S MAIDEN NAME: Anna Shine

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 218-05-0512
17. INFORMANT: Edward Skuhr ADDRESS: 1726 N. Wolfe Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxiation
DUE TO carbon monoxide poisoning
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Long Point, Maryland (A. A. Co.)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 27, 1949 ? p.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Inhalation of carbon monoxide fumes from defective coal furnace

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: C. J. Culbreth M D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12-28-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/31-49
24C. NAME OF CEMETERY OR CREMATORY: Meadow Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949
REGISTRAR'S SIGNATURE: Hunter for Williams, Reg.
25. FUNERAL DIRECTOR: Philip Herring Sons, Calvert St. 2054

VS 151

178c

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81331

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81331

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELIZABETH M. EPPLER

2. DATE OF DEATH Dec 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 602 W. 36th St.

c. Length of stay in Baltimore — Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D STREET ADDRESS (If rural, give location) 602 W. 36th St 13-07

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9 AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Aug 15 1894 | 55 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12 CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Md. | |

13. FATHER'S NAME Frank Korrell

14 MOTHER'S MAIDEN NAME Antoinette Kovar

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO |
|---|---|---|
| — | — | — |

17 INFORMANT Henry L. Eppler ADDRESS 602 W. 36th St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Extensive infiltration of lungs with blocking off of breathing areas

DUE TO Probable malignant adenomatosis of the lungs.

(B)

DUE TO Recurrent pulmonary infections of both virus & bacterial

(C) Diabetes mellitus also Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH
2 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | requested - refused | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* March 5 1949, *to* Dec 26, 1949, *that I last saw the deceased alive on* Dec 26 1949 *and that death occurred at* 12 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry D. McCarty M. D. | 87 W. Preston St | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C NAME OF CEMETERY OR CREMATORY | 24D LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Lorraine Park. | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Hunter for Williams, M.D. | Paul C. Edmondson | 5015-17 Harford Ave. |

VS 150

57E

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81332

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. G81332

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Blanche E. Lutz.

2. DATE OF DEATH: Dec 27 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 602 W. 34th St
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 602 W. 34th St 12-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | married | Oct 3, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife. | | Md. | |

13. FATHER'S NAME: Richard Lilly

14. MOTHER'S MAIDEN NAME: Margaret Feather

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Lydia M. Lutz | 602 W. 34th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) myocardial degeneration
DUE TO hypertensive & Arteriosclerotic cardio vascular disease.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 16 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Dec 9, 1931, to Dec 27, 1949 that I last saw the deceased alive on Dec 26, 1949, and that death occurred at 4 a. m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| George H. Kemp M. D. | 3030 Edmondson Ave | Dec 29, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Loudon Park. | Frederick Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams M.D. | Karl E. Hammett Jr. | 3015-17 Edmondson Ave. |

VS 150

927

G81333

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81333 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John Smith

2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy

c. Length of stay in Baltimore: 29 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2423 Howard Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Separated | May 25 1896 | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Virginia | U.S.A. |

13. FATHER'S NAME: John Smith

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Same | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) hypoglycemia, probable — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) retroperitoneal sarcoma with liver metastasis — DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☑ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11/29, 1949 *to* 12/27, 1949 *that I last saw the deceased alive on* 12/27, 1949 *and that death occurred at* 8:45 A.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John H Ragavelis M. D. | Mercy Hospital | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/29/49 | Mt Calvary Cem | Brooklyn Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Emma Lou Williams, M.D. | Chas O. Wilson | 1109 Broadway |

VS 150

46 H

Correct age is especially important. Physicians please write the cause of death clearly and legibly.

MS--133015
G81334

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81334

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Frances Anderson

2. DATE OF DEATH 12-28-49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore 23 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 207 N. Aisquith St.

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Widowed | Aug. 6, 1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Virginia | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| (Deceased) | (Deceased) |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Records | Baltimore City Hospitals--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Arteriosclerotic heart disease
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.
Diabetes melitus with acidosis and gangrene of extremity.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 11-22-49<br>11-10-49 | Supracond. amputation--Lt. mid. Metatarsal Amp.<br>Lt. sympathectomy | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 10-29- , 1949 *to* 12-28- , 1949, *that I last saw the deceased alive on* 12-28-49 19 , *and that death occurred at* 3:05 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Logan M. D. | B.C.H.--4940 Eastern Ave. | 12-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-2-50 | Mt Calvary Cem | Brookeye Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Hunting for Williams, M.D. | Elroy O. Wilson | 1000 Brantly ave |

VS 150

61

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81335 ✓ G81335

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

443 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Bessie Palees

2. DATE OF DEATH: Dec 29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 114 S. Patterson Park Ave.
C. Length of stay in Baltimore: 42 Yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 1-05
D. STREET ADDRESS (If rural, give location): 114 S. Patterson Park Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months, Days | If under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | 1885 | 64 Yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Russia. | USA. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Samuel Shurgin | Sarah ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Joseph Palees | 114 S. Patterson Park Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Degenerative Cardio-vascular Disease - Arteriosclerosis and (Hypertension) — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cerebral Vascular Thrombosis — 24 hours

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* ____, 19 47 *to* 12-29-, 19 49 *that I last saw the deceased alive on* 12-28-, 19 49 *and that death occurred at* 6 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. Abramson M.D. | 1109 N. Calvert St | 12-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-29-49 | Adath Israel Beth Isaac Balto. Md. | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams M.D. | Sol Levinson & Bros | 1124-26 N. North Avenue |

VS 150

937

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81336 ✓ H20.1 G81336

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) MINNIE LOVETT

2. DATE OF DEATH Dec. 29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland 2302 Ocala Ave

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore 45 years (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY 2302 Ocala Ave
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 15-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 1879 | 70 | — / — | — / — |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | New York City | U.S.A |

13. FATHER'S NAME David Diamondstone

14. MOTHER'S MAIDEN NAME Fannie Diadoudstone

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Sarah Greber | 2302 Ocala Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs
DUE TO
(B) Myocarditis — 18 yrs
DUE TO
(C) Aortic insuf

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE WORK ☐ | |

22. *I hereby certify that I attended the deceased from* about 20 years 19__, *to* Dec 29, 1949 *that I last saw the deceased alive on* Dec 29, 1949 *and that death occurred at* 5:30A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C M Bernyard M. D. | 3455 Park Heights Ave | Dec 29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 30/49 | Hebrew Randalls Cemetery | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | Sol Levinson & Bro | North ave |

HS-150

92a

G81337

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81337 Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): William HARRY FREDERICK

2. DATE OF DEATH: December 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 312 S. Newkirk Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | June 10 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Holder own iron | Md Dry Dock | Baltimore Md | U.S.A. |

13. FATHER'S NAME: Henry Frederick

14. MOTHER'S MAIDEN NAME: Barbara ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ------- | 215-10-9465 | Rose Frederick | 312 S Newkirk St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized carcinomatosis;

DUE TO bronchogenic carcinoma

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| B S Fisher M.D | [X] | 12-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 30 1949 | Oak Lawn Cemetery | Eastern Ave Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR (ADDRESS) |
|---|---|---|
| DEC 29 1949 | Lennington Williams, M.D. | Duffel Bro. 1800E Lombard St. |

VS 351

47c

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81338

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

420.0 G81338

BIRTH NO. G81338 — Registered No.

1. NAME OF DECEASED (Type or Print): WALTER BENNETT

2. DATE OF DEATH: December 25, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1122 Sarah Ann Street 1 F O r

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12-25-1884
9. AGE (In years last birthday): 65 — If under 1 Year: Months, Days — If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Bennett
14. MOTHER'S MAIDEN NAME: Susan Dutton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mary Bennett — ADDRESS: 1122 Sarah Ann St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Arteriosclerotic heart disease | 1 year |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST — DUE TO | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

23A. SIGNATURE: R S Fisher, M D
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: Dec. 26, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-30-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cem.
24D. LOCATION (City, town, or county) (State): Lansdowne Md.

DATE RECEIVED BY LOCAL REGISTRAR:
25. FUNERAL DIRECTOR: Mr Katie R Williams
ADDRESS: 322 N Schroeder St

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81339

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81339

Registered No.

1. NAME OF DECEASED (Type or Print) BERNARD PROUT

2. DATE OF DEATH December 26, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 103 W. Henrietta Avenue

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 103 Henrietta Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | colored | Single | 12-12 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Md. | U.S.A. |

13. FATHER'S NAME Alfred Prout

14. MOTHER'S MAIDEN NAME Eliza Talbot

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W.I | | Ruth Colbert | Leadenhall St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Chronic alcoholism
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Earl L Royer M.D. | | 27 Dec 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 12-30-49 | Balto. National | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12-29-49 | Remington for Williams, M.D. | Mrs Kate R Williams | 322 N Schroeder St. |

VS 151

77D

G81340 BALTIMORE CITY HEALTH DEPARTMENT G81340

CERTIFICATE OF DEATH 170 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lillie Bowley White

2. DATE OF DEATH 12-25-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 773 Dover St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto.
D STREET ADDRESS (If rural, give location) 773 Dover St. 2-01

5. SEX Female
6. COLOR OR RACE Col.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH 6-24-1887
9. AGE (In years last birthday) 62
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cambridge Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Samuel R. Bowley ADDRESS 773 Dover St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Respiratory failure
DUE TO
ANTECEDENT CAUSES
(B) Carcinoma Breast,
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/23, 1949, to 12/25, 1949, that I last saw the deceased alive on 12/24, 1949, and that death occurred at 5.30 p. m., from the causes and on the date stated above.

23A. SIGNATURE L. Skorofsky M. D. M. D.
23B. ADDRESS 601 N. Howard St.
23C. DATE SIGNED 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 12-29-49
24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.
24D. LOCATION (City, town, or county) Edgewood (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE Huntington Williams, M. D.
FUNERAL DIRECTOR Miss Katie R. Williams
ADDRESS 22 N. Schroeder St.

VS 150

50

G81341 ✓593X G81341

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): RICHARD WHITE
2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1805 W Franklin St
C. Length of stay in Baltimore: 23 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21 01
D. STREET ADDRESS (If rural, give location): 1805 W. Franklin St.

5. SEX: Male
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Mar 20 1900
9. AGE (In years last birthday): 49 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY: Lumber Yard.
11. BIRTHPLACE (State or foreign country): N. Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Thomas White
14. MOTHER'S MAIDEN NAME: Emily Watkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Isaac White ADDRESS: 806 N. Fulton

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemmorhage
DUE TO
(B) Hypertension Nephritis
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/24 1949 *to* 12/27 1949 *that I last saw the deceased alive on* 12/27 1949 *and that death occurred at* 4:32 *m., from the causes and on the date stated above.*

23A. SIGNATURE: David Franklin M. D.
23B. ADDRESS: 122 W See ↑
23C. DATE SIGNED: 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-30-1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem
24D. LOCATION (City, town, or county, state): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Mrs Katie R. Williams
ADDRESS: 322 N Schroeder St

VS 150

83a

APPROVED BY MEDICAL EXAMINER

G81342

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

466 G81342 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): FRANK LOUIS WAGNER

2. DATE OF DEATH: Dec. 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): US Marine Hospital Wyman Pk. Drive & 31st St.

C. Length of stay in Baltimore: ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1335 Brunt St. 17-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | col | Married | 5/20/01 | 48 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cook | Seafarer | Mobile, Ala. | USA |

13. FATHER'S NAME: Frank L. Wagner

14. MOTHER'S MAIDEN NAME: Mary ?

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 055-16-0035 | Records- US Marine Hospital, Balto, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis, pulmonary, cause not determined

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

CERTIFICATION APPROVED BY
R S Fraker, M. D.
MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH: Unknown

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* DEAD ON ARRIVAL - 11AM, 19__, to ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John L. Wilson, Medical Director M. D. | US Marine Hospital, Balto, Md. | 12/27/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-30-1949 | W. Arlington Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 12/29/49 | Livingston Williams, M.D. | Mrs Kate R Williams | 3224 Edmondson Ave |

VS 150

111a

ACC Room

CERTIFICATE CORRECTED 12-29-49 ✓

G81343

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

151

G81343 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Clarence Fortune

2. DATE OF DEATH: DEC 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 716 Aisquith St. 10-04

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 6-24-88 1889 | 60 61 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Porter | Theatre | Baltimore, Md | U.S.A. |

13. FATHER'S NAME: Charles Jones

14. MOTHER'S MAIDEN NAME: Estelle Anderson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 2176-1786

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of stomach

DUE TO

(B) ? peritonitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) ? coronary occlusion ? cerebral metastasis

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-28 1949 *to* 12-28 1949, *that I last saw the deceased alive on* 12-28 1949, *and that death occurred at* 2½ *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Jerome E. Chaney Jr. M.D. | JOHNS HOPKINS HOSPITAL | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 1/1/50 | Cedar Lawn Memorial Park | Balto. | Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| | Hunter for Williams, M.D. | Robert H. Young | 1632 E. Monument St |

VS 150 To be Approved by Medical Examiner

46B

G81344 ✓ 592 G81344

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): AMANDA D. REESE

2. DATE OF DEATH: 12-28-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 503 Sheridan Avenue

c. Length of stay in Baltimore: Yrs. LIFE Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY
503 Sheridan Avenue
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, Md. 27-10
D. STREET ADDRESS (If rural, give location): 503 Sheridan Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 12-24-1870 | 79 | | 5 | |

| 10A. USUAL OCCUPATION (Give kind of work done during greatest part of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Dec'd. - | Medical | Balto., Md. - | |

13. FATHER'S NAME: (?)

14. MOTHER'S MAIDEN NAME: (?)

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | | Mr. LeRoy Hauer | 415 York Rd. - |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chron Myocarditis | 5 yr |
| DUE TO (B) | Chron Arteriosclerosis Nephritis | 5 yr |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Acute Cardiac Dilatation | 4 mos |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Varicose Ulcer L Leg. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* May, 1949 *to* Dec 28, 1949, *that I last saw the deceased alive on* May 28, 1949, *and that death occurred at* 3 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. N. Bishop M. D. | 503 Sheridan Av | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-30-49 | Cathedral Cem | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND 131a |

VS 150

G81345

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420.1

Registered No. G81345

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SARA MARGARET GEWEKEN (also Sara G. Fronimos)

2. DATE OF DEATH: 27 Dec 49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hosp

C. Length of stay in Baltimore: 40 yrs. (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 13-04
D. STREET ADDRESS (If rural, give location): 2724 Parkwood Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| F | White | Widowed | March 21, 1876 | 73 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | home | Maine | |

13. FATHER'S NAME: Frederick Dorsey

14. MOTHER'S MAIDEN NAME: Margaret -

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT / ADDRESS |
|---|---|---|
| - | - | Mr. Dorsey Geweken Woodley Ave., Reisterstown, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) | Acute Coronary Occlusion | |
| | DUE TO | | |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | | |
| | DUE TO | | |
| | (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | Inoperable Carcinoma of Biliary Tract. | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12/24 | Inoperable Metastatic Carcinoma of Biliary Tract. | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/21, 1949 *to* 12/27, 1949 *that I last saw the deceased alive on* 12/27, 1949, *and that death occurred at* 11 45 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ernest G. Cerasano M. D. | Maryland Gen'l Hosp | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Woodlawn Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

46F

G81346

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 4201 G81346

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Emil F. Graas

2. DATE OF DEATH: Dec 27-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3012 Keaver Ave

C. Length of stay in Baltimore: Yrs. 27 Mos. 2 Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3016 Keaver Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | married | Oct 14-1884 | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinist | | Germany | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 213-10-7229

17. INFORMANT: Mrs. Frieda Graas ADDRESS: 3016 Keaver

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 Min.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Jan 19 to Dec 27, 19 49 that I last saw the deceased alive on Dec 17, 1949, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Walter T. Karkis, M. D. | 4331 Harford Rd | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-30-49 | Parkwood | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | Leonard J. Luck - 5305 | Harford |

VS 150

94a

G81347

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81347

BIRTH NO. M-22820 — Registered No. 751

1. NAME OF DECEASED (Type or Print): MARY BURY — 2. DATE OF DEATH: Dec 27 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland — B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 526 S Bouldin St

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission): A. STATE Maryland — B. COUNTY — C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore Md — D. STREET ADDRESS (If rural, give location): 526 S Bouldin St

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | April 8 1945 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child. | — | Baltimore Md | U.S.A. |

13. FATHER'S NAME: Joseph L Bury

14. MOTHER'S MAIDEN NAME: Bertha Broom

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Joseph L Bury | 526 S Bouldin St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Lobar Pneumonia (Bilateral) — DUE TO

ANTECEDENT CAUSES

(B) Pulmonary Edema, Acute — DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Spina Bifida.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 1, 1944 *to* Dec 27, 1949 *that I last saw the deceased alive on* Dec 27, 1949 *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| E. A. Flannigan Jr. M. D. | 3503 Fait ave. | 12-27-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 30 1949 | Holy Redeemer | Belair Road |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | John C. Mosan | 3000 E Baltimore St |

157B

G81348

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 9-29-8

Registered No. G81348

BIRTH NO.

1. NAME OF DECEASED (Type or Print): THOMAS MOORE HAMMOND N-995

2. DATE OF DEATH: December 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harbor--Caroline & Dock Streets
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Frederick
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Frederick
D. STREET ADDRESS (If rural, give location): 140 W. 4th St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Divorced | Dec. 26, 1903 | 46 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frederick, Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Thomas M. Hammond
14. MOTHER'S MAIDEN NAME: Ida Bell Snyder
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 705-07-4224
17. INFORMANT: Thomas M. Eichelberger ADDRESS: Fred'k, Md

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Asphyxia due to drowning
DUE TO
(B) Acute alcoholism
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Harbor
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Found Harbor at Caroline & Dock Sts.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Found 12-28-49 9:15 a.m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur? Found drowned

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Carl Boyer M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED: 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12-31-49
24C. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
24D. LOCATION (City, town, or county) (State): Frederick, Maryland.
25. FUNERAL DIRECTOR: M. R. Atchison & Son ADDRESS: Fred'k, Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81349

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4 2 1

G81349

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ELIZABETH MEUSHAW

2. DATE OF DEATH Dec. 28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland BALTO. MD.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1307 DECATUR ST
C. Length of stay in Baltimore 60 yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE Md.
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTO. 24-01
D STREET ADDRESS (If rural, give location) 1307 DECATUR ST.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hrs. Min. |
|---|---|---|---|---|---|---|
| FEM | W | WIDOWED | JUNE 10-1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WIFE | | IRELAND | |

13. FATHER'S NAME UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | NONE | MRS. IRKIN | 1307 DECATUR ST |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Chronic Myocarditis | 1 month |
| DUE TO (B) | Arteriosclerosis | 6 months |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 27, 1949 *to* Dec 28, 1949, *that I last saw the deceased alive on* Dec 26 1949, *and that death occurred at* 2:30 A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| C. S. Wheble M.D. | [illegible] | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC. 30/49 | WESTERN CEMETERY | EDMONDSON AVE Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | KRAUSE FUNERAL HOME | 1216 S. CHARLES ST. |

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CERTIFICATE CORRECTED 1-3-50

G81350

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81350

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Gertrude Lally

2. DATE OF DEATH: Dec. 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2919 Cresmont Ave.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 12 A
D. STREET ADDRESS (If rural, give location): 2919 Cresmont Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | About 72 yrs | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | | Baltimore, Maryland | |

13. FATHER'S NAME: Michael Nolan

14. MOTHER'S MAIDEN NAME: Bridget Dougherty

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Martin M. Lally, | 4616 Gwynn Oak Ave. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Uraemia

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) Caranoma Bladder

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 4/2/49 | Caremoma of Bladder | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 4/49, 19__, to 12, 1949, that I last saw the deceased alive on 12/15, 1949, and that death occurred at 4:5 p m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Frank A. Galeni M.D. | 1137 N. Monument St. | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Cathedral Cemetery | Baltimore, Maryland. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Huntington Williams, M.D. | H. A. Meares & Son | 605 N. Calvert St. |

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G81351

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

44 3 Registered No. G81351

BIRTH NO

1. NAME OF DECEASED (Type or Print): Christina Wolf

2. DATE OF DEATH: 12/28/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2603 Dulaney St.

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 20-05
D. STREET ADDRESS (If rural, give location): 2603 Dulany St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | April 21, 1879 | 70 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Balto. Md. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Beulah Parrish | 2603 Dulaney St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Cardiac Dilatation — INTERVAL BETWEEN ONSET AND DEATH: One day

DUE TO

(B) Hypertensive Cardio Vascular disease ?

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from Dec 19 49 to Dec 27, 1949 that I last saw the deceased alive on Dec 27, 1949 and that death occurred at 4 A.M., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Harry Glassman M. D. | 2617 Mosher Ave | Dec 29 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Loudon Pk. 3801 Frederick Rd. | Balto. 29, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 29 1949 | Hunter for Williams, M.D. | Harry F. Dintaffe | 4101 Edmondson Ave. |

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G81352

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

56.1

Registered No. G81352

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frank Rewers

2. DATE OF DEATH: 12-26-49

3. PLACE OF DEATH: A. Baltimore City, Maryland — Balto -

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1927 Bank Street

c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Md.
B COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto - 31 - Md.
D STREET ADDRESS (If rural, give location): 1927 Bank St. 2-01

5. SEX: M.
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Singl
8. DATE OF BIRTH: 9-2-1880
9. AGE (In years last birthday): 69 (If under 1 Year: Months, Days; If under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Michal Rewers
14. MOTHER'S MAIDEN NAME: Lena ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lena Rewers - ADDRESS: 1927 Bank St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: ? months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 1, 1949, to Dec 26, 1949 that I last saw the deceased alive on Dec 26, 1949, and that death occurred at m., from the causes and on the date stated above.

23A. SIGNATURE: George D. Lyons, M. D.
23B ADDRESS: 437 W Baltimore
23C DATE SIGNED: 12/28/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 12/30/49
24C. NAME OF CEMETERY OR CREMATORY: St. Stanislaus
24D. LOCATION (City, town, or county) (State): Balto - Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 29 1949
REGISTRAR'S SIGNATURE: Hunter Jon Williams, M.D.
25. FUNERAL DIRECTOR: Lilly & Zirkin
ADDRESS: 403 N. Wolfe St.

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G81353

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81353 Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print) JENNIE SHERRILL

2. DATE OF DEATH December 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital

C. Length of stay in Baltimore 30 Yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 518 Eden Street

5. SEX female | 6. COLOR OR RACE colored | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) Widow | 8. DATE OF BIRTH 9/14/1891 | 9. AGE (In years last birthday) 58 | If under 1 Year: Months Days | If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Salisbury N.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Pairinger

14. MOTHER'S MAIDEN NAME Mary Mooney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT Essie Hampton ADDRESS 36 N. Eden St.

## MEDICAL CERTIFICATION

16. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Occlusion
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inquiry & Inspection (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE Carl L. Rogers M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED Dec. 28, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE 12/31/1949 | 24C. NAME OF CEMETERY OR CREMATORY Roanoke Va. | 24D. LOCATION (City, town, or county) (State) Roanoke Virginia

DATE RECEIVED BY LOCAL REGISTRAR DEC 29 1949 | REGISTRAR'S SIGNATURE [illegible] | 25. FUNERAL DIRECTOR Elroy O. Wilson ADDRESS 1000 Brantly Ave.

VS 1H

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

G81354

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

008 Registered No.

G81354

BIRTH NO

1. NAME OF DECEASED (Type or Print): GERTRUDE BALTIMORE

2. DATE OF DEATH: 12/27/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY: HARFORD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~BALT~~ BELAIR

c. Length of stay in Baltimore: Years — Mos. — Days 9

D. STREET ADDRESS (If rural, give location): ? Bond Street

5. SEX: F

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M

8. DATE OF BIRTH: 1894 - Mar. 4

9. AGE (In years last birthday): 55
If Under 1 Year: Months — Days — If Under 24 Hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Upper Bill MD. ??

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Edward Haven

14. MOTHER'S MAIDEN NAME: Elizabeth —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: —

17. INFORMANT: SELF
ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)

(A) BRONCHOPNEUMONIA

DUE TO

(B) ETIOLOGY UNDETERMINED POSSIBLE TB.

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 12/27/49

19B. MAJOR FINDINGS OF OPERATION: BRONCHOSCOPY EDEMA & NECROSIS BRONCHIAL TREE

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/18/ , 1949 to 12/27/ , 1949 that I last saw the deceased alive on 12/27/ , 1949 , and that death occurred at 2:50 P. m., from the cause and on the date stated above.

23A. SIGNATURE: J. J. Pennebaker Jr. M.D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 12/27/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/31/49

24C. NAME OF CEMETERY OR CREMATORY: Hendon Hill Cemetery

24D. LOCATION (City, town, or county) (State): Bel-Air Md. Harford

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949

REGISTRAR'S SIGNATURE: Cynthia for Williams

25. FUNERAL DIRECTOR: Elmer E. Pollock

ADDRESS: Havre de Grace Md.

VS 150

0

107

G81355

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

794 Registered No. G81355

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Laura Steffan

2. DATE OF DEATH 12-28-1949.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pine Crest Sanitorium 600 South Chapelgate Lane

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lansdowne
D. STREET ADDRESS (If rural, give location) 2200 Hammonds Ferry Rd

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widow | 2/14/1858 | 91 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | Md | |

13. FATHER'S NAME (Unknown) Brown

14. MOTHER'S MAIDEN NAME Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Christian G. Kessler | 2817 Hammonds Ferry Rd |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Senility without dementia — INTERVAL BETWEEN ONSET AND DEATH: ?

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 10/5/ 1944 to 12-28 1949 that I last saw the deceased alive on 12-27- 1949 and that death occurred at 1:05 p m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M. D. | 2030 W. Fayette Street | 12-28-1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY or CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Cedar Hill | A.A.Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington Williams, M.D. | Wm. Cook Inc. | 1217 St. Paul St. |

VS 150

1620

G81356

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81356

BIRTH NO

Registered No.

1. NAME OF DECEASED (Type or Print): ANNE B. STOLL

2. DATE OF DEATH: DEC. 28-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 43 N. CULVER ST
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
c. Length of stay in Baltimore LIFE Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MD
B. COUNTY
43 N. CULVER ST.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 43-N. CULVER ST. 20-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| FEMALE | WHITE | SINGLE | DEC. 9, 1869 | 80 | 19 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSE WORK | | BALTIMORE MD | U.S. |

13. FATHER'S NAME: ADOLPH STOLL

14. MOTHER'S MAIDEN NAME: MARY KELLERMAN

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | NONE | MRS. JOSEPH STOLL | 2838 ST. PAUL ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | arteriosclerotic Cardio-Vasc. Dis. | ? |
| DUE TO | arteriosclerosis | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | nephrosclerosis | ? |
| DUE TO | arteriosclerosis | ? |
| (C) | Coronary Heart Disease | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 27, 1949 *to* Dec. 28, 1949 *that I last saw the deceased alive on* Dec. 27, 1949 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Kulevitz, M.D. M.D. | 344 N. Milton Ave. | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | DEC. 31-1949 | NEW CATHEDRAL | BALTIMORE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | [illegible] for [illegible] | Dill Bros. - Frederick Ave. | 3109 |

VS 150

131a

G81357

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

260 Registered No. G81357

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MAMIE GOUGH

2. DATE OF DEATH: Dec 27-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2830 Hudson St.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 1-01
D. STREET ADDRESS (If rural, give location): 2830 Hudson street.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Married | Nov 21-1891 | 58 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Balto Md. | U.S. |

13. FATHER'S NAME: Daniel Goetz

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Herbert Gough | 2830 Hudson street. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | (INTERVAL BETWEEN ONSET AND DEATH) |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Hypertensive arteriosclerotic | 4 - 6 Years. |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO c.v. disease | |
| | (B) Diabetes Mellitus | Several years. |
| | DUE TO | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None. | | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No. | No injury. | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| No Injury. m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 9, 1946, *to* Dec. 27, 1949 *that I last saw the deceased alive on* Dec. 27, 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [illegible] M. D. | 11 E. Chase St. Balto. 2, Md. | 12.28.49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12-30-49 | Parkwood Cem. | 7225 Eastern Ave |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | acting for Williams, M.D. | John J. Duda Inc | 2829 Hudson St. |

VS 150

61

G81358

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

81.0

G81358 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George C. Bienlein

2. DATE OF DEATH 12/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Halethorpe
D. STREET ADDRESS (If rural, give location) 3427 Washington Blvd.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | March 25, 1905 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Pipe Fitter | B & O Railroad | Baltimore Maryland | U S A |

13. FATHER'S NAME John A. Bienlein

14. MOTHER'S MAIDEN NAME Eleanor Forteman

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | Mrs. Anna N. Bienlein | 3427 Washington Blvd. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Hepatitis
DUE TO Uremia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Cirrhosis of liver
DUE TO Ascites

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 12/12/49 | Cirrhosis of liver | YES ✓ NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-7-49, 19__, *to* 12-29-49 19__, *that I last saw the deceased alive on* 12-29-49 19__, *and that death occurred at* 9 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | 1213 Light Street | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/2/50 | Meadowridge Mem. Pk. | Washington Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington Williams, M.D. | John J. Cannon & Son | 2108 Hollins St. |

VS 150

124C

G81359

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81359

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Sadie Ludwig

2. DATE OF DEATH: 12/29/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1271 Sargeant St.

c. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 21-07
D. STREET ADDRESS (If rural, give location): 1271 Sargeant St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 12/19/1885 | 64 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Work | at Home | Baltimore Md. | U S A |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Lillian E. Miles | Sargeant St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Chronic Nephritis — Interval between onset and death: 1 yr.

DUE TO

(B)

DUE TO

(C) Arthritis dorsal spine — 5 yr.

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 7-3, 19[illegible] *to* 12-28, 1949, *that I last saw the deceased alive on* 12-28, 1949, *and that death occurred at* 9:05 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| John P. Ulrich Jr. M. D. | 1227 Wash Blvd | 12-29-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | New Cathedral Cem. | 4300 Old Frederick Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Hunter Williams, M.D. | John J. Cowen & Son | 1310 Gilmor St. |

VS 150

G81360

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81360

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ROSE CATHERINE CARROLL
2. DATE OF DEATH: Dec 28, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2118 Allendale Road
C. Length of stay in Baltimore: 60 Yrs.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore, 16, 15-48
D. STREET ADDRESS (If rural, give location): 2118 Allendale Road

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | Oct. 28, 1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House wife | | Massachusetts | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Kyran McNeill | Lucy McKenna |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Thomas F. Carroll (Son) | 2118 Allendale Rd Baltimore, Md |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

DUE TO

(B) Arteriosclerotic Cardiovascular Disease — 10 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| M. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from July 28 to Dec 28, 1949 that I last saw the deceased alive on Dec. 28, 1949 and that death occurred at 11 P.M., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Millard F. Trabord Jr. M.D. | 3400 Woodbine Ave. Balt. 7 Md | Dec 28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Cathedral Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington for Williams, M.D. | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

G81361 X ✓ G81361

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William Henry Deery

2. DATE OF DEATH: Dec. 29 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: New York
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Schenectady
D. STREET ADDRESS (If rural, give location): 1180 Van Antwerp

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE MARRIED WIDOWED DIVORCED (Specify):
8. DATE OF BIRTH: Aug. 31 - 1900
9. AGE (In years last birthday): 49
If under 1 Year: Months Days
If under 24 hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Designer
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mass
12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: Harry Deery
14. MOTHER'S MAIDEN NAME: Margaret Killian

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes
(If yes, give war or dates of service): #1 & #2
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary Deery, ADDRESS: 1180 Van Antwerp Rd. Schenectady, N. Y.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) coronary thrombosis

DUE TO

(C) Hypertension & arteriosclerotic cardio vascular disease

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 24, 1949 *to* Dec. 29, 1949 *that I last saw the deceased alive on* Dec 29, 1949, *and that death occurred at* 1:35 *p.m., from the causes and on the date stated above.*

23A. SIGNATURE: Edith H. Schoenrich, M. D.
23B. ADDRESS: Johns Hopkins Hosp.
23C. DATE SIGNED: 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Removal
24B. DATE: 12/30/49
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): Schnectady, N. Y.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Schimunek Funeral Home, Inc.
ADDRESS: 2601-3-5 E. Madison St.

VS 150

927

G81362

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

✓ 76

G81362 Registered No.

BIRTH NO. 49-27743

1. NAME OF DECEASED (Type or Print): Baby Boy Longley

2. DATE OF DEATH: Dec. 23, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hosp. For The Women of Md.

c. Length of stay in Baltimore: one Years / Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore - 15 28 01
D. STREET ADDRESS (If rural, give location): 4407 Groveland Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Single | Dec. 22, 1949 | | | 18 / 20 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | none | maryland | USA. |

13. FATHER'S NAME: James Baird Longley

14. MOTHER'S MAIDEN NAME: Helen Post Kent.

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | none | Helen Longley | 4407 Groveland Ave. Balto - 15 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Extreme prematurity | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | maternal — acute hydramnios | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. 22, 1949 *to* Dec. 23, 1949 *that I last saw the deceased alive on* Dec. 23, 1949 *and that death occurred at* 1 45 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William G. Spencer Jr. M.D. | Hosp. for Women of Md. | 12-24-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS [illegible] | DEC 27 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81363

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

7635

G81363 Registered No.

BIRTH NO. 49-28510

1. NAME OF DECEASED (Type or Print): BABY BOY LAWSON

2. DATE OF DEATH: DEC 24, 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: MARYLAND
B COUNTY: BALTIMORE
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 1004 SHARP ST

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: 12 Days

6. SEX: MALE
6. COLOR OR RACE: COLORED
7. SINGLE MARRIED WIDOWED DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: DEC 24, 1949
9. AGE (In years last birthday): Months 12 Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10B KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ISAAH WILLIAMS
14. MOTHER'S MAIDEN NAME: ANNIE MAE LAWSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: MOTHER ADDRESS: 1004 SHARP ST. BALT, MD

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death) (A) | ASPIRATION PNEUMONIA | 12 hrs |
| DUE TO (B) | PREMATURITY | 10 days |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | SEPSIS | 10 days |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory street, office bldg. etc.):
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22 I hereby certify that I attended the deceased from DEC 12, 1949, to DEC 24, 1949, that I last saw the deceased alive on 12-24, 1949, and that death occurred at 10:45 P. m., from the causes and on the date stated above.

23A SIGNATURE: Jerome Ambury M.D.
23B ADDRESS: University Hospital
23C DATE SIGNED: DEC 25, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B DATE:
24C NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL DEC 28 1949
24D LOCATION (City, town, or county) (State):

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: Hattie for Williams, Jr.
25 FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

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G81364

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

H 75 G81364 Registered No.

BIRTH NO. 49-16492

1. NAME OF DECEASED (Type or Print): ANTON WILLIAMS
2. DATE OF DEATH: December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 1312 Upton Street 17-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | U | U | | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | K | |

13. FATHER'S NAME: U
14. MOTHER'S MAIDEN NAME: U

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) BRONCHOPNEUMONIA
DUE TO
(B) ACUTE TRACHEOPHARYNGITIS
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Paul L Reyer M.D. | ☐ ☐ ☐ | 12-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 27 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington Williams, Jr. | Commissioner of Health | |

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Correct age if especially important. If unknown, please write the cause of death clearly and legibly.

G81365

# CERTIFICATE CORRECTED 1-23-1950

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

19D

Registered No. G81365

BIRTH NO. 49-15209

1. NAME OF DECEASED (Type or Print) ~~JERRY---ADAMS~~ GERALD WILSON

2. DATE OF DEATH December 20, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION ("If not in hospital or institution, give street address or location") University Hospital

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D STREET ADDRESS (If rural, give location) 2211 N. Howard Street

| 5. SEX | 6 COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | colored | U | June 15, 1949 | | 6 | | | |

| 10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B KIND OF BUSINESS OR INDUSTRY | 11 BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | Baltimore, Md. | |

13. FATHER'S NAME Willie Lee Adams

14 MOTHER'S MAIDEN NAME Jennie Lee Wilson

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16 SOCIAL SECURITY NO | 17 INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lobar Pneumonia, Left
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☒ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE W. J. McClafferty M D | 23B CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C DATE SIGNED Dec. 20, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B DATE | 24C. NAME OF CEMETERY OR CREMATORY UNIVERSITY MEDICAL SCHOOL | 24D LOCATION (City, town, or county) (State) DEC 27 1949

DATE RECEIVED BY LOCAL REGISTRAR DEC 30 1949 | REGISTRAR'S SIGNATURE Huntington Williams, Jr. | 25 FUNERAL DIRECTOR Commissioner of Health | ADDRESS

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Corrections are to be typewritten. Physicians: please write the cause of death clearly and legibly.

G81366

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43

G81366

Registered No. 3698

1. NAME OF DECEASED (Type or Print): Lillian Holton

2. DATE OF DEATH: Dec 28, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md

B. COUNTY:

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2210 morris st

D. STREET ADDRESS (If rural, give location): 2210 morris st

c. Length of stay in Baltimore: Yrs. 5ife Mos. Days

5. SEX: 7

6. COLOR or RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): m

8. DATE OF BIRTH: Feb 1881

9. AGE (If over 1 year last birthday): 68 — If under: Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Smeas

14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: George Holton — ADDRESS: 2210 morris st

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerosis + hypertension — Unknown

DUE TO

(C) Myocarditis — Unknown

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12—27—1949, *to* 12—28—1949, *that I last saw the deceased alive on* 12—28—1949, *and that death occurred at* 4P *m., from the causes and on the date stated above.*

23A. SIGNATURE: Frank A. Saunders M. D.

23B. ADDRESS: 1029 N. Stricker St.

23C. DATE SIGNED: 12—30—49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12-31-49

24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn.

24D. LOCATION (City, town, or county) (State): md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: George D. Kelson — ADDRESS: 1302 Pennsylvania Ave

VS 150

937

G81367

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81367

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Joseph Johnson

2. DATE OF DEATH December 29/1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 27 N. Carey St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GOOD SAMARITAN HOME

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1419 RIGGS AVE 16 0 2

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | Negro | MARRIED | 6/6/1876 | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | Construction | Petersburg Va | U. S. |

13. FATHER'S NAME Joseph Johnson

14. MOTHER'S MAIDEN NAME Agnes

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | no | | Mrs Ida Johnson (W) | 1419 Riggs Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Hemmorhage & Right Hemiplegia
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) Chronic Myocarditis & (None) Myocardial Degeneration (Rheumatic) ?

INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* June 1, 1949 *to* Dec. 28, 1949 *that I last saw the deceased alive on* Dec 27, 1949, *and that death occurred at* 1:15 P *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Melvin N. Borden M. D. | 2030 W. FAYETTE ST | 12/28/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | [illegible] | Chas H Orpen & Co | Eutaw & Lanvale Sts |

VS 150

93 c

G81368

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

5-7-2

G81368 Registered No.

BIRTH NO. 49-23434

1. NAME OF DECEASED (Type or Print): ALBERT F. HUNTER

2. DATE OF DEATH: December 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 608 Dolphin Street
C. Length of stay in Baltimore: 2 mos. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 608 Dolphin Street 17-04

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 26, 1949
9. AGE (In years last birthday): If Under 1 Year: Months 2, Days; If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Infant)
10B. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Lawrence Knox
14. MOTHER'S MAIDEN NAME: Virginia Hunter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Virginia Hunter ADDRESS: 608 Dolphin Street

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Acute pulmonary edema
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Interstitial pneumonia

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: H. J. McClafferty M.D
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [X]
23C. DATE SIGNED: Dec. 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Dec. 30, 1949
24C. NAME OF CEMETERY OR CREMATORY: Mt. Auburn
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: Emilie Lyon Williams, Asst.
25. FUNERAL DIRECTOR: Holland Funeral Home
ADDRESS: 1631 Druid Hill Ave.

VS 151

114E

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81369

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

441 Registered No. G81369

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Peter Green

2. DATE OF DEATH: December 2 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 526 Pierce Street
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-01
D. STREET ADDRESS (If rural, give location): 526 Pierce Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| M | C | Unk. | Unk. | 65 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unk. | | Unk | U.S.A. |

13. FATHER'S NAME: Unk.

14. MOTHER'S MAIDEN NAME:

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cardio Vascular Renal | |
| DUE TO | | |
| (B) | Disease - Uremia | 1 yr. |
| DUE TO | | |
| (C) | Hemiplegia | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-15- 1949 *to* 12-1- 1949, *that I last saw the deceased alive on* 12-1- 1949, *and that death occurred at* 7½ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| W. T. Jackson M. D. | 600 N. Arlington Ave | 12-7-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | | |

UNIVERSITY MEDICAL SCHOOL DEC 15 1949

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington Williams, M.D. | | |

Commissioner of Health

VS 150

131a

G81370 26 185

D. O. A

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81370
Registered No.

1. NAME OF DECEASED (Type or Print): William Woodley
2. DATE OF DEATH: Dec 9, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Acct Room
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL
C. Length of stay in Baltimore: 13 Yrs. — Mos. — Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 6 Md
D. STREET ADDRESS (If rural, give location): 18 N. Wolfe St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months: Days | If Under 24 Hours Hours: Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Single | -18- | 53 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | a | |

13. FATHER'S NAME: Gilbert Woodley
14. MOTHER'S MAIDEN NAME: Sarah Ford

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary tuberculosis
Tuberculous mediastinitis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

CERTIFICATION APPROVED BY
[signature] M. D.
CHIEF OR ASST. MEDICAL EXAMINER

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* Dec 9, 1949 *to* Dec 9, 1949 *that I last saw the deceased alive on* Dec 9, 1949 *and that death occurred at* 11:26 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William W Winternitz M. D. | JOHNS HOPKINS HOSPITAL | 12-9-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 20 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 30 1949 | Hunter for Williams, M.D. | Commissioner of Health |

Medical Ex Case To be approved 136

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81371

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

286.6

Registered No. G81371

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Joseph Simmons

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 14-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (Last birthday) Years / If under 1 year: Months / Days / If under 24 hours: Hours / Min. |
|---|---|---|---|---|
| M | Colred | | Aprox. 48 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | | U S |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Nutritional Deficiency
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/19, 1949, to 12/20, 1949, *that I last saw the deceased alive on* 12/20, 1949, *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Lewis W. Jacques M.D. | Provident Hosp | Dec 21 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | DEC 21 1949 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 30 1949 | Huntington Williams M.D. | Commissioner of Health |

71

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81372

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81372

Registered No.

1. NAME OF DECEASED (Type or Print): WILLIAM WOOD

2. DATE OF DEATH: December 18, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1203 Smithson Street
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1203 Smithson Street

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | U | U | 43 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): A
10B. KIND OF BUSINESS OR INDUSTRY: A
11. BIRTHPLACE (State or foreign country): K
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: N O
14. MOTHER'S MAIDEN NAME: N O
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): N
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: N
ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary and disseminated tuberculosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE: W. J. McClafferty, M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: 12-19-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): DEC 27 1949

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS: Dept. of Health

VS 15T

Correct age if uncertain. Physicians, please write the cause of death clearly and legibly.

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G81373

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81373

BIRTH NO

1. NAME OF DECEASED (Type or Print): Benjamin Coplin

2. DATE OF DEATH: Dec. 28, 49

3. PLACE OF DEATH: A. Baltimore City, Maryland — JOHNS HOPKINS HOSPITAL

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fullerton Md.

D. STREET ADDRESS (If rural, give location)

c. Length of stay in Baltimore: 3 mos. (Yrs. Mos. Days)

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov 22 '91 | 9. AGE (In years last birthday): 58 (If Under 1 Year: Months, Days; If Under 24 Hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Balt. County Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Coplin

14. MOTHER'S MAIDEN NAME: Elizabeth Graham

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO

17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Infarction of Rt Lung; embolic — INTERVAL BETWEEN ONSET AND DEATH: 5 d

DUE TO

(B) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 26, 1949 to Dec 28, 1949 that I last saw the deceased alive on Dec. 28, 1949, and that death occurred at [illegible] m., from the causes and on the date stated above.

23A. SIGNATURE: David Lukens M. D. | 23B ADDRESS | 23C DATE SIGNED: 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial | 24B DATE: Jan 1 '49 | 24C. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cem. | 24D LOCATION (City, town, or county) (State): Loreley Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949 | REGISTRAR'S SIGNATURE: Hunting for Williams, Mgr | 25 FUNERAL DIRECTOR — ADDRESS: Mrs Robert G. Elliott & Daughter, 1129 N. Carrollton Ave

VS 150

G81374

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81374

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Grace Smith

2. DATE OF DEATH: Dec 27 49

3. PLACE OF DEATH: A Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission): A STATE Md. B COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 809 Hillen St

C CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Yrs. Mos. Days

D STREET ADDRESS (If rural, give location): 809 Hillen St 5-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | C. | Widow | July 22 874 | 75 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | King & Queen County Va | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Archer Folley | Amy Folley |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S ADDRESS |
|---|---|---|
| | | Mrs. Curtis Johnson 809 Hillen St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congestive Heart Failure

DUE TO (B) Arteriosclerotic Heart Disease

DUE TO (C) Arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH:

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* July 20, 1949 *to* Dec 27, 1949 *that I last saw the deceased alive on* Dec 26, 1949, *and that death occurred at* 6A *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| F. R. Adams M. D. | 1222 N. Broadway | Dec 28 49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec 30/49 | Mt Calvary Cem | A. A. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Huntington Williams, M.D. | Wm Robert A. Elliott Dft | 930 1129 N. Carrollton St |

VS 150

G81375

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

16 Registered No. G81375

1. NAME OF DECEASED (Type or Print): Sr. M. IRMENGARDE SSND DREBES

2. DATE OF DEATH: Dec. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto
D. STREET ADDRESS (If rural, give location): 901 Aisquith St

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hosp.

c. Length of stay in Baltimore: Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | W | Single | June 5, 1887 | 62 | 6 | 24 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sister

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Drebes

14. MOTHER'S MAIDEN NAME: Mary Funcke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Monocytic Leukemia, chronic — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Nasopharyngeal carcinoma — DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION: Dec 24, 1949

19B. MAJOR FINDINGS OF OPERATION: Nasopharyngeal carcinoma

20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 24, 19 49 *to* , 19 , *that I last saw the deceased alive on* Dec 29, 19 49 *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M.D.

23B. ADDRESS: Mercy Hosp.

23C. DATE SIGNED: Dec 29, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/31-49

24C. NAME OF CEMETERY OR CREMATORY: Mt. Calvary

24D. LOCATION (City, Town, or County) (State): Baltimore

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949

REGISTRAR'S SIGNATURE: [signature] Williams

25. FUNERAL DIRECTOR: [illegible]

ADDRESS:

VS 150

45F

681376

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 681376

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Josephine Balcer

2. DATE OF DEATH Dec 29 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland 3032 Mc Elderry St

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN Baltimore
D. STREET ADDRESS (If rural, give location) 3032 Mc Elderry St

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow

8. DATE OF BIRTH Feb 22 1896

9. AGE (If less than 1 year, state months, days, hours) 53

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Baltimore Md.

12. CITIZEN OF (Country) U.S.A.

13. FATHER'S NAME Asthony Olszewski

14. MOTHER'S MAIDEN NAME Maryanna Gordniewski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Frances Balcer ADDRESS 3032 Mc Elda

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Myocardial insufficiency DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (a) STATING THE UNDERLYING CONDITION LAST

(b) Coronary occlusion DUE TO

(c) Arteriosclerotic cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Interval between onset and death

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 20 1949 to Dec 29 1949 that I last saw the deceased alive on Dec 27 1949, and that death occurred at 11½ P m. from the causes and on the date stated above.

23A. SIGNATURE J. Shorolak M.D. M.D.

23B. ADDRESS 601 N. Monroe St.

23C. DATE SIGNED 12/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE Jan 2 1950

24C. NAME OF CEMETERY OR CREMATORY Sacred Heart

24D. LOCATION (City, town or county) Balto. County

DATE RECEIVED BY LOCAL REGISTRAR DEC 30 1949

REGISTRAR'S SIGNATURE Emmett Jones Williams

25. FUNERAL DIRECTOR AND ADDRESS John A. Welker 401 S. Charles Street

VS 150

131a

G81377

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81377

1. NAME OF DECEASED (Type or Print): SAM LITTLE

2. DATE OF DEATH: December 12, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sath Baltimore General Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 52 W. West Street 73-01

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | U | U | 42 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | O |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary Tuberculosis
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Partial Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: Earl L Royer, M.D. | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR [X] | 23C. DATE SIGNED: 12-13-49

24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL DEC 21 1949 | 24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949 | REGISTRAR'S SIGNATURE: [illegible] | 25. FUNERAL DIRECTOR | ADDRESS: [illegible] Commissioner of Health

VS 151

13B

MS—37096

G81378

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

40.0 G81378

Registered No.

1. NAME OF DECEASED (Type or Print): William Paul

2. DATE OF DEATH: 12-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 63 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): No Home

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 8-11-1870
9. AGE (In years last birthday): 79 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Paul
14. MOTHER'S MAIDEN NAME: Mary E. Shenton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Records—Baltimore City Hospitals ADDRESS: 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
(A) Arteriosclerotic Heart Disease With Failure
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
( Malignant Cells With Pleural Fluid

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17- , 1938, *to* 12-19- , 1949 *that I last saw the deceased alive on* 12-19- , 1949, *and that death occurred at* 5:00 P. M., *from the causes and on the date stated above.*

23A. SIGNATURE: P. L. Rogan M. D.
23B. ADDRESS: B.C.H.—4940 Eastern Ave.
23C. DATE SIGNED: 12-27-49

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State)
DEC 29 1949

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR
ADDRESS: [illegible] Dept. of Health

VS 150

47E

G81379 101957

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81379

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Elizabeth Catherine Nauman

2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Balto. City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 2664 Presbury St Z 16

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: April 23- 1857
9. AGE (In years last birthday): 92 Yrs.
If under 1 Year: Months Days
If under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: H. Bernard Helling
14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Records B.C.H. 4940 Eastern Ave. ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic cardio-vascular disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg. etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6- 10- 1946 *to* 12- 29- 1949, *that I last saw the deceased alive on* 12- 29- 1949, *and that death occurred at* 1.05AM *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B ADDRESS: B.C.H. 4940 Eastern Ave.
23C DATE SIGNED: 12-29-1949.

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B DATE: 12/2/50
24C NAME OF CEMETERY OR CREMATORY: Mt Holy Redeemer
24D LOCATION (City, town, or county) (State): Belair Road

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE:
25 FUNERAL DIRECTOR: Mildred J. Blight ADDRESS: 6009 Harford Rd

VS 190

93D (14)

Correct age is especially important. Physicians, please write the cause of death clearly and legibly.

G81380 ✓ G81380

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): John W. Washington

2. DATE OF DEATH: 12/28/49

3. PLACE OF DEATH: A. Baltimore City Maryland Balto Md

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): a. STATE Maryland b. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1013 Harlem Ave

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-01

c. Length of stay in Baltimore: Yrs. 2 Mos. Mos. Days Yrs.

D. STREET ADDRESS (If rural, give location): 1013 Harlem Ave

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE MARRIED WIDOWED DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 1-15-1895

9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 Hours: Hours | Min.: 54 11 17

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10B. KIND OF BUSINESS OR INDUSTRY: R R

11. BIRTHPLACE (State or foreign country): Hartford Co Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Wright

14. MOTHER'S MAIDEN NAME: Beulah Tilley Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 705-09-2[illegible]

17. INFORMANT: Mrs Beulah Baker ADDRESS: 1013 Harlem Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-3 19[illegible] *to* 12-28 19 49 *that I last saw the deceased alive on* 12-27 19 49 *and that death occurred at* 10:00 [illegible] *from the causes and on the date stated above.*

23A. SIGNATURE: W. Atwell Jones M. D.

23B. ADDRESS: 5 S Adolph St

23C. DATE SIGNED: 12-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: Jan 4 1950

24C. NAME OF CEMETERY OR CREMATORY: John Wesley

24D. LOCATION (City, township, county) (State): Abingdon Harford Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 30 1949

REGISTRAR'S SIGNATURE: Emilie [illegible] Williams M.D.

25. FUNERAL DIRECTOR: Howard K. McCormick & Son ADDRESS: 130 Abingdon Md

VS 150

G81381 ✓ 4.0 G81381

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): MR. INNOCENTE DIPIETRO

2. DATE OF DEATH: 12/29/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital
C. Length of stay in Baltimore: 36 (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 4405 La Salle Ave 26-01

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: Dec 17, 1892
9. AGE (In years last birthday): 57 (If under 1 year: Months / Days; If under 24 hours: Hours / Min.): 12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trombone Player
10B. KIND OF BUSINESS OR INDUSTRY: Musician (Band)
11. BIRTHPLACE (State or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Dipietro, Michael
14. MOTHER'S MAIDEN NAME: FARIAS, ANGELINA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 215-03-7251
17. INFORMANT: Miss H. Anderson ADDRESS: Church Home and Hospital

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Lymphatic Leucemia.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 1-5 years (Not Known)

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 23, 1949 to Dec. 29, 1949 that I last saw the deceased alive on Dec 29, 1949, and that death occurred at 2:20 A m., from the causes and on the date stated above.

23A. SIGNATURE: Lee M. Howard M.D.
23B. ADDRESS: Church Home and Hospital
23C. DATE SIGNED: 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: January 2/1950
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
24D. LOCATION (City, town, or county) (State): 4430 Belair Rd. Baltimore Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: Huntington Williams, Inc.
25. FUNERAL DIRECTOR: Grant Weller Hoce ADDRESS: 322 S. High St.

VS 150

74a

BIRTH NO. C81382

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. C81382

1. NAME OF DECEASED (Type or Print): WILBERT PACE

2. DATE OF DEATH: December 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1900 Division Street 17-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | | Dec 24- | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fireman, Penna RR. | | Union Springs S.C. | |

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Willie Mae Pace | 534 W Lanvale St |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial Degeneration

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* In_uction *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
Autopsy, Inspection or Inquiry

| 23A. SIGNATURE | M.D. | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| Earl L Royster | | | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-3-49 | Dr Eggan Cem. | Bessemer, Ala. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Thurlow for Williams, M.D. | William A Jackson | 916 Penna Ave |

93D

ES-134537
G81383

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G81383

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Alice E. Paulus

2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals
c. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D STREET ADDRESS (If rural, give location): 75 Kingston Rd.

5. SEX: Female
6 COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8 DATE OF BIRTH: Dec. 11, 1879
9 AGE (In years last birthday): 70 | If Under 1 Year Months, Days | If Under 24 Hours Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (State or foreign country): Md
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (D)
14 MOTHER'S MAIDEN NAME: (D)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None
16 SOCIAL SECURITY NO: ?
17 INFORMANT: Records*Balto, City Hospitals ADDRESS 4940 Eastern Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage
DUE TO
(B) Hypertensive Cardio Vascular Disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
[illegible] Kramer, M.D.
per R S Fisher M. D.
CHIEF OR ASST. MEDICAL EXAMINER

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29, 1949, *to* 12-29, 1949 *that I last saw the deceased alive on* 12-29 1949, *and that death occurred at* 6:50 P.M. *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B ADDRESS: 4940 Eastern Avenue
23C DATE SIGNED: 12-29-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/2/1950
24C NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D LOCATION (City, town, or county) (State): Baltimore County

DATE RECEIVED BY LOCAL REGISTRAR: DEC 30 1949
REGISTRAR'S SIGNATURE: Lenton Williams, Jr.
25 FUNERAL DIRECTOR ADDRESS: Lilly & Zeiler Inc. 403 S. Wolfe St. Balto.

VS 150
To Be Approved By The Chief Medical Examiner.

93D

BIRTH NO. 81384

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 81384

1. NAME OF DECEASED (Type or Print): Mary Vingenza Schiavo
2. DATE OF DEATH: Dec 28 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland 905 Eastern ave
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Baltimore
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 905 Eastern ave.

c. Length of stay in Baltimore: 70 yrs. Yrs. Mos. Days 3-02

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female. | White | Widowed | April 22. [redacted] | 78. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Italy | |

13. FATHER'S NAME: Georgia Sorio
14. MOTHER'S MAIDEN NAME: Catherine Menondo

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial failure due to Acute Coronary Occlusion
DUE TO
(B) generalized arteriosclerosis due to Senile Psychosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) 2 hrs
(B) 24 hrs
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 29, 1949 *to* 12/28, 1949, *that I last saw the deceased alive on* 12/24, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23A. SIGNATURE: S. C. Feldman M. D.
23B. ADDRESS: 31 [redacted] Belair Rd
23C. DATE SIGNED: 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial.
24B. DATE: Dec 31. 1949
24C. NAME OF CEMETERY OR CREMATORY: Holy Redeemer
24D. LOCATION (City, town, or county) (State): 4400 Belair Road.

DATE RECEIVED BY LOCAL REGISTRAR
REGISTRAR'S SIGNATURE: Dorothy Jones Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS: Wardell J. Pepper 2135 Highland Ave

VS 150

97

G81385

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

53 G81385 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Emily M. Kearney

2. DATE OF DEATH December 29/49

3. PLACE OF DEATH: a. Baltimore City, Maryland 4936 Park Heights Ave

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Balto.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-18

d. STREET ADDRESS (If rural, give location) 4936 Park Heights Ave

c. Length of stay in Baltimore 8 years (Yrs. Mos. Days)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | August 29, 1899 | 50 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY |
|---|---|---|---|
| Housewife | | England | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Michael Kelly | Isabelle Coutts |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Schizo Carcinoma of Colon — Interval between onset and death: 2 Weeks

DUE TO

(B) Hysterectomy — 2 yrs

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C) Metastatic Carcinoma to Pelvic organs — 6 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT — 2 yrs

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| 11-15-49 | Ope Carcinoma | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Sept 1949 to Jan 29, 1949 *that I last saw the deceased alive on* Dec 29, 1949, *and that death occurred at* 8:15 P.M., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| C. A. Evans M.D. | 7211 York Rd | 12-30-49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Dec. 31/49 | Druid Ridge | Pikesville Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | [illegible] for Williams, M.D. | Spring Byers Sons | Pikesville |

VS 150

46E

G81386

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81386

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CARRIE A. RINGGOLD
2. DATE OF DEATH: 12/30/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Maryland General
C. Length of stay in Baltimore: Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. Pikesville
D. STREET ADDRESS (If rural, give location): 4105 Essex Rd #17

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | White | Widowed | 5/10/82 | 67 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Baltimore Md | U.S.A. |

13. FATHER'S NAME: Charles Leo Meyers
14. MOTHER'S MAIDEN NAME: Hester A. Machova

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs. Irene Ringgold | 342 Oakford Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary Thrombosis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. I hereby certify that I attended the deceased from 12/22, 1949 to 12/30, 1949 that I last saw the deceased alive on 12/30, 1949, and that death occurred at 2:07 Am., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Charles J. Blazek M.D. | Maryland General | 12/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | January 2 '50 | Druid Ridge | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 30 1949 | Beatrice Williams, Asst. | Young Byers | 500 Park Ave. |

VS 150

61

CERTIFICATE CORRECTED 1-3-50 ✓ X 1

G81387

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81387

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MRS. ETHEL MEIER

2. DATE OF DEATH 12-30-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Agnes Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Halethorpe — 27
D. STREET ADDRESS (If rural, give location) 248. Clyde ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | white | married | 8-13-1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Maryland | U.S.A. |

13. FATHER'S NAME John McGee

14. MOTHER'S MAIDEN NAME Jennie Jones

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Henry Meier | Same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute postern coronary occlusion | 6-7 hrs |
| DUE TO | | |
| ANTECEDENT CAUSES | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) | |
| DUE TO | | |
| | (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Diabetes mellitus | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/29, 1949 *to* 12/30, 1949 *that I last saw the deceased alive on* 12/30, 1949 *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Herbert J. Zerikos M.D. | St. Agnes Hospital | 12/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 1/2/50 | London Park | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Trustee for Williams, Reg. | Fulton Cook Inc | 1219 Park Ave |

VS 150

61

C81388

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

447 Registered No. C81388

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAX G. FRANCKOWIAK

2. DATE OF DEATH Dec. 29, 1949

3. PLACE OF DEATH Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
d. STREET ADDRESS (If rural, give location) 2502 Foster Ave. 1-03

a. Length of stay in Baltimore Yrs. Mos. Days

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower
8. DATE OF BIRTH June 2, 1878
9. AGE (In years last birthday) 71
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10B. KIND OF BUSINESS OR INDUSTRY Kirball & Taylor
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME FRANCKOWIAK FRANCKOWIAK
14. MOTHER'S MAIDEN NAME Mary (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 21-01-7005
17. INFORMANT Walter Lockhart, 2502 Foster Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Senility
DUE TO
ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) Arteriosclerosis and
DUE TO
(C) hypertension (moderate)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: years

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1949 *to* Dec. 1949 *that I last saw the deceased alive on* ____ 19__, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE Sigmund R. Novak M.D.
23B. ADDRESS 404 S. Patt. Pk. Ave.
23C. DATE SIGNED 12/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/3/50
24C. NAME OF CEMETERY OR CREMATORY Holy Rosary
24D. LOCATION (City, town, or county) (State) Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR DEC 31 1949
REGISTRAR'S SIGNATURE Tutie L. Williams, M.D.
25. FUNERAL DIRECTOR William Cook, Inc., ADDRESS 1913 St. Paul St.

VS 150

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97

G81389

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

900.0 G81389 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Ellen Iglehart — N 821.0

2. DATE OF DEATH: 12/30/49 2 P.M.

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Union Memorial Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2105 Huntington Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Femele | White | Widowed | June 19, 1881 | 68 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | England | U.S.A. |

13. FATHER'S NAME: Thomas Wharton

14. MOTHER'S MAIDEN NAME: Margaret (?)

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Hospital Records | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 11-30-49

DUE TO

(B) Fracture Right Femur — 11-29-49

DUE TO

(C) Arteriosclerotic

ANTECEDENT CAUSES

DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

CERTIFICATION APPROVED BY
for: C.J. Rubinski, M.D.
CHIEF DEPUTY ASST. REG. CAL EXAMINER
R.H. Fraley

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov 29, 1949 | Intertrocanteric Fracture Rt Femur | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| Accident | Home | 2105 Huntington Ave |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| 11-29-49 m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☑ | Fell down steps |

22. I hereby certify that I attended the deceased from Nov 25, 1949, to Dec 30, 1949, that I last saw the deceased alive on Dec 30, 1949, and that death occurred at 1:20 P m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Paul E. Gordon M.D. | Union Memorial Hospital | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 2nd 1950 | Mountain Park | Parkville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Huntington Williams | W.M. Cook | Inc. 127 E. Paul St. |

VS 150

186a

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 681390

681390

BIRTH NO.

1. NAME OF DECEASED (Type or Print): DELPHIA B. MILLER

2. DATE OF DEATH: 12/30/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 638 Cotton St

5. a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 638 Cotton St

c. Length of stay in Baltimore: Yrs. Mos. Days

6. SEX: Female
7. COLOR OR RACE: White
8. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
9. DATE OF BIRTH: Sept 16 1875
10. AGE (In years last birthday): 74 — If under 1 Year: Months Days — If under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10B. KIND OF BUSINESS OR INDUSTRY: Private Family
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Joseph Miller
14. MOTHER'S MAIDEN NAME: Julia Patterson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 211-09-3234
17. INFORMANT — ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerotic Cardiovascular Disease
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Inspection Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* X, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.
(Autopsy, Inspection or Inquiry)

23a. SIGNATURE: John R Davis M D
23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR X
23c. DATE SIGNED: 12/30/49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/3/49
24c. NAME OF CEMETERY OR CREMATORY: St Peters
24d. LOCATION (City, town, or county) (State): Baltimore Md

DATE RECEIVED BY LOCAL REGISTRAR: DEC 31 1949
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR — ADDRESS: Wilborn & Son Inc 934 S Paul St

VS 151

93D

G81391

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

G81391

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Dinah Mc Gill

2. DATE OF DEATH: Dec 29, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE: Md. B. COUNTY: Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Brooklyn

D. STREET ADDRESS (If rural, give location): 515 Hammonds Ln

5. SEX: Female

6. COLOR or RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov 8, 1912

9. AGE (In years last birthday): 37

If under 1 year: Months, Days. If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Texas

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Jones

14. MOTHER'S MAIDEN NAME: Unknown Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: JOHNS HOPKINS HOSPITAL ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

(B) Rheumatic Heart Disease, Inactive Mitral Stenosis & Insufficiency Relative Tricuspid Insufficiency — 17 months

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-29-1949 to 12-29-1949 that I last saw the deceased alive on 12-29-1949 and that death occurred at 10 50 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Robert C. Hawthorne M. D.

23B. ADDRESS: JOHNS HOPKINS HOSPITAL

23C. DATE SIGNED: 12/30/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 12/31/49

24C. NAME OF CEMETERY or CREMATORY: St. Peters

24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 31 1949

REGISTRAR'S SIGNATURE: Huntington Williams M.D.

25. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 E. Paul St.

VS 150

92B

C81392

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 8 30.9

Registered No. C81392

1. NAME OF DECEASED (Type or Print) THOMAS A. KILMON

2. DATE OF DEATH December 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bethlehem Steel ship repair yard 1101 Key Highway
C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 824 W. 35th Street 1306

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct 16, 1890 | 57 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Crane Operator | Ship Yard | Md | |

13. FATHER'S NAME Thomas H. Kilmon

14. MOTHER'S MAIDEN NAME Julia Emery

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| — | — | |

17. INFORMANT Susanna Kilmon ADDRESS 824 W. 35th St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Multiple Fractures of Pelvis
(B) Rupture of Spleen
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(C)
DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | ship repair yard | Bethlehem Steel, 1101 Key Highway |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [X] | NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| December 29, 1949 1.15 p.m. | | | Run over by a crane car |

22. *I certify that I took charge of the remains described above, held an* autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Emil L. Hoyle M.D. | | Dec. 30, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/2/50 | Moreland Park | Taylor Ave. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | [illegible] | Frank C. Thompson Jr. | 3615-17 Liberty Ave. |

VS 151

176

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81393

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

54.4 G81393

Registered No.

BIRTH NO. 49-23683

1. NAME OF DECEASED (Type or Print) CHRISTINE ANN ROHRBACK

2. DATE OF DEATH Dec. 29, 1949

3. PLACE OF DEATH
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 844 W. 37th St.

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 844 W. 37 ~~th~~ St. 13 07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | Dec 27 1949 | | 2 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Austin F. Rohrback | Margaret L. Boston. |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | Austin F. Rohrback | 844 W. 37th St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Heart Disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec 22, 1949, *to* Dec 29, 1949, *that I last saw the deceased alive on* ____ 19__ *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edward L. Harman M. D. | 4031 Falls Rd | 12/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Woodlawn. | Woodlawn Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Emma Lee Williams, M.D. | Paul C. Schramm & Son | 3651-53 Lakewood Ave. |

VS 150

157E

G81394

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81394 Registered No.

1. NAME OF DECEASED (Type or Print): Anna L. Ennis

2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH: a. Baltimore City, Maryland; b. FULL NAME OF HOSPITAL OR INSTITUTION: 802 N. Castle St (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 802 N. Castle 7-05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | W | M. | 11/12/1883 | 66 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| AT HOME | | BALTIMORE MD | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WM. MC ELWEE | MARY BELLIS |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO | — | JOHN P. ENNIS | 802 N. CASTLE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocarditis & Cardiac — Interval between onset and death: Unknown

DUE TO Decompensation

(B)

DUE TO

(C) Diabetes Mellitus — Unknown

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* _____ (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

| 23a. SIGNATURE | 23b. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23c. DATE SIGNED |
|---|---|---|
| Robert B. McFadden M.D | | 12-30-49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | JAN. 3, 1950 | MORELAND MEMO. | PARKVILLE MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | | Ullrich Funeral Home | 7007 Harford Rd |

VS 151

61

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81395

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81395

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CONCETTA BICKEL

2. DATE OF DEATH 12/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE MARYLAND B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BALTIMORE
D. STREET ADDRESS (If rural, give location) 1917 E. FAYETTE ST 6-04

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) SOUTH BALTIMORE HOSP

c. Length of stay in Baltimore Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W. | NOV. 5, 1893 | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| STORE KEEPER | SHOE STORE | BALTIMORE | |

13. FATHER'S NAME MICHAEL SAVARESE

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | WM. L. BICKEL | 1917 E. FAYETTE |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Myocardial infarction

DUE TO

(B) Coronary occlusion

DUE TO

(C) Coronary arteriosclerosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-5-1949 *to* 12-24-1949 *that I last saw the deceased alive on* 12-29-1949 *and that death occurred at* 10 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thos. D. Grayson M. D. | 50, Bolton St. Balto | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, Town, or County) (State) |
|---|---|---|---|
| Burial | 1/2/50 | Holy Redeemer | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25 FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Beatrice Williams | Abbott Funeral Home | Fulton Ave |

VS 150

94a

Correct age as repeatedly important. Physicians: please write the causes of death clearly and legibly.

G81396

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81396

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET P. DEAN (Also known as PHENIE)

2. DATE OF DEATH Dec. 30, 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland 2317 E. Fayette St.,

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Lifetime (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 2317 E. Fayette St., 6-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | July 18, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| At home | | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Philip Lohrey | Louise Solomon |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | --- | William E. Lean 2317 E. Fayette St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: April 1946 Continuous

DUE TO

(B) Diabetes, Interstitial

DUE TO

(C) Nephritis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. I hereby certify that I attended the deceased from April 1946 to Dec 30, 1949, that I last saw the deceased alive on Dec 30 1949 and that death occurred at 16 04 m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Edwin W. Clift M. D. | 810 Brenbeg Road | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 2, 1950 | Baltimore | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| DEC 31 1949 | [illegible] for Williams, R | Ulrich Funeral Home 2008 Orleans St., |

VS 150

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G81397 : BALTIMORE CITY HEALTH DEPARTMENT 163 Registered No. G81397

BIRTH NO.

# CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print): JAMES J. MANNION
2. DATE OF DEATH: Dec. 29 1949
3. PLACE OF DEATH: A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 146 N. EAST AVE.
c. Length of stay in Baltimore: Yrs. LIFE Mos. Days
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A STATE: MARYLAND
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D STREET ADDRESS (If rural, give location): 146 N. EAST AVE. 6-01
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: MAR. 3, 1884
9. AGE (In years last birthday): 65 If Under 1 Year: Months Days If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNKNOWN
10B. KIND OF BUSINESS OR INDUSTRY: U.S. Navy yard
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: JOHN MANNION
14. MOTHER'S MAIDEN NAME: CECELIA GOLD
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MRS MAMIE MANNION ADDRESS: 146 N EAST AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of lung, left — DUE TO — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO
(C) acute myocardial failure

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/ , 19 49, to 12/29/49, that I last saw the deceased alive on 12/29, 1949, and that death occurred at 12:15 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Stanley B. Kliancowicz, M. D.
23B. ADDRESS: 3500 Eastman Ave
23C. DATE SIGNED: 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 2, 1950
24C. NAME OF CEMETERY OR CREMATORY: Oakdawn Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 31 1949
REGISTRAR'S SIGNATURE: Hunter Williams, M.D.
25. FUNERAL DIRECTOR: John A. Moran
ADDRESS: 3001 E Balto St Balto 24

VS 150

47D

G81398

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 144 G81398

1. NAME OF DECEASED (Type or Print) Rosa Rieser

2. DATE OF DEATH Dec 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland Esplande Apt,

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Same B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location) Esplande Apt. 12-01

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore Life Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Nov, 4, 1860. | 89 | 1 | 25 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | None | | Aus |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Reuben Reser | Celie Stetten |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | None | Miss Rieser | Esplande Apt. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Squamous Cell Carcinoma of

DUE TO Buccal Mucous Membrane & Mouth (Right Side)

(B) involving Cervical glands

DUE TO

(C) Arterio Sclerosis due to Senility —

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 5 mos. April 1948

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* April 27, 1948 *to* Dec 29, 1949 *that I last saw the deceased alive on* Dec 29, 1949 *and that death occurred at* 11.57 A m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Irwin J. Cooper M. D. | 1111 Esplanade | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 1, 1950 | Hebrew Friend Ship | Phiadelphia Rd. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | [illegible] | David Sondheim & Son | 1902 Eutaw place |

VS 150

David Sondheim & Son 45E

G81393

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

331 Registered No. G81393

1. NAME OF DECEASED (Type or Print): ADA L. DEHNE.

2. DATE OF DEATH: DEC 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 304 N. MONASTERY AVE

b. Length of stay in Baltimore: LIFE (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
D. STREET ADDRESS (If rural, give location): 304 N. MONASTERY AVE 20-07

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: AUG 14, 1877
9. AGE (In years last birthday) / If under 1 Year: Months, Days / If under 24 Hours: Hours, Min.: 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: CHARLES DEHNE.
14. MOTHER'S MAIDEN NAME: SARAH R. ROBINSON.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) —
(If yes, give war or dates of service) —
16. SOCIAL SECURITY NO —
17. INFORMANT / ADDRESS: WM. G. DEHNE - 304 N. MONASTERY AVE

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
I (A) Cerebral apoplexy — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO
(B) Hypertension, essential
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1946 to Dec 29, 1949 that I last saw the deceased alive on Dec 28, 1949, and that death occurred at 11 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Morris W. Steinberg M. D.
23B. ADDRESS: 410 N. Hilton St
23C. DATE SIGNED: Dec. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24B. DATE: JAN 2 1950
24C. NAME OF CEMETERY OR CREMATORY: NEW CATHEDRAL
24D. LOCATION (City, town, or county) (State): OLD FREDERICK ROAD, MD

DATE RECEIVED BY LOCAL REGISTRAR: DEC 31 1949
REGISTRAR'S SIGNATURE: [illegible]
25. FUNERAL DIRECTOR / ADDRESS: Austin E. Donovan - 3818 Roland Ave

VS 150

83a

G81400

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

17 Registered No. G81400

1. NAME OF DECEASED (Type or Print): John J Mulvaney

2. DATE OF DEATH: 12/30/49

3. PLACE OF DEATH: A. Baltimore City, Maryland — 912 Parkwood

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hamilton Home Nursing Home

C. Length of stay in Baltimore: Yrs. Don't Know Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Baltimore B. COUNTY Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md

D. STREET ADDRESS (If rural, give location): 2112 St Paul St 13-06

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months Days | If under 24 hours: Hours Min. |
|---|---|---|---|---|---|---|
| M. | W. | Not Known | | 66. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Not Known | | Not Known | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Not Known | Not Known |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mrs Mungo | 2112 Parkwood |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Carcinomatosis — Interval between onset and death: 2 Mos.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Prostatic Carcinoma — 1 yr.

DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec 5, 1949, *to* Dec 30, 1949, *that I last saw the deceased alive on* Dec 30, 1949, *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Robert B. Lunney M.D. | 28 Mycrest Rd | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Druid Heights | Woodlawn, Hilltop Rd |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Beatrice Williams | J. J. Delaney Sons | 1318 Eutaw Pl |

VS 150

516

G81401

JL - 133588

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

G81401

Registered No.

1. NAME OF DECEASED (Type or Print) **Joseph Bryant**

2. DATE OF DEATH **12-29-49**

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) **Baltimore City Hospitals 4940 Eastern Ave.**
c. Length of stay in Baltimore **50 yrs.** (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Md.** B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**
D. STREET ADDRESS (If rural, give location) **814 N. Stricker St.**

| 5. SEX | 6. COLOR or RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) If Under 1 Year: Months Days / If Under 24 Hours: Hours Min. | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|---|---|---|
| **M** | **Negro** | **Married** | **Dec. ? 1879** | **70** | | |

| 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|
| **N. C.** | |

13. FATHER'S NAME **(D)**

14. MOTHER'S MAIDEN NAME **?**

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | **216-03-1041** | **B. C. H. Records, 4940 Eastern Ave.** |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) **Hypertensive Arteriosclerotic Cardio-vascular Disease** | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST | (B) DUE TO | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ Yes ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* **11-19-49**, 19 , *to* **Dec. 29**, 19**49** *that I last saw the deceased alive on* **Dec. 29**, 19**49** *and that death occurred at* **12.20 PM** *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| **J. B. Rogers** M. D. | **4940 Eastern Ave.** | **12-30-49** |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| **Burial** | **1-1-50** | **arbutus** | **md** |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| **DEC 31 1949** | **Evelyn F. Williams** | **George D. Kelson** | **1303 Brentman st** |

937

Correct ages in carpentry, improvements. Physicians: please write the cause of death clearly and legibly.

G81402 Harry I

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

63 G81402
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Harry I. LeCompte
2. DATE OF DEATH: Dec. 30-49
3. PLACE OF DEATH: A. Baltimore City, Maryland
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 623 N. Potomac St.
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 7-01
c. Length of stay in Baltimore: Yrs. Mos. Days
D. STREET ADDRESS (If rural, give location): 623 N. Potomac St.
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: July 17-1886
9. AGE (In years last birthday): 64 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Power House Operator
10B. KIND OF BUSINESS OR INDUSTRY: Balto. Smelting & Refining Co.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel LeCompte
14. MOTHER'S MAIDEN NAME: Thomas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Sallie LeCompte ADDRESS: 623 N. Potomac St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 13, 1949 to Dec. 30, 1949, that I last saw the deceased alive on Dec. 30 1949 and that death occurred at 16 m., from the causes and on the date stated above.

23A. SIGNATURE: Thos. E. Nelson M.D.
23B. ADDRESS: 3 W. Biddle
23C. DATE SIGNED: 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 2-1950
24C. NAME OF CEMETERY OR CREMATORY: Greenmount Cem.
24D. LOCATION (City, town, or county) (State): Balto. Md.

DATE RECEIVED BY REGISTRAR: DEC 31 1949
REGISTRAR'S SIGNATURE: Theodore Thos. Williams, M.D.
25. FUNERAL DIRECTOR: John A. Miller ADDRESS: 2334 Jefferson St.

VS 150

477

G81403

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81403

BIRTH NO

1. NAME OF DECEASED (Type or Print): Anna Barbara Kempler

2. DATE OF DEATH: Dec. 29 - 1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Balto.
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6815 Fait Ave
c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 6815 Fait Ave, 26 05

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | married | 7/25/1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | — | Baltimore Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Joseph Plewacki | Cepkuda Kowalewski |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | George Kempler | same as above |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH — INTERVAL BETWEEN ONSET AND DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B) Hypertensive Cardiovascular Disease

DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT SUICIDE HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* April 49 *to* Dec 29 49, *that I last saw the deceased alive on* Dec 28, 1949, *and that death occurred at* 4:55 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Samuel Wolfe M.D. | 3 E. 40th Ave | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/3/50 | Sacred Heart | Hamm's Hill Rd. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | | John D Connelly. | Essex, Md. |

93D

Correct age if apparently inaccurate. Physician: please write the name of nearest relative or friend.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81404

1. DECEASED: Julia Wren

2. DATE OF DEATH: Dec. 28, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): 711 S. Freemont Ave.
a. STATE: Md.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 711 S. Freemont Ave.

b. HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Same — 22 Yrs

c. Length of stay in Baltimore: 22 Yrs. Mos. Days

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | C | W | Nov. 23, 1904 | 45 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Domestic | | Lynchburg, Va. | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Carrie Turner

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | William Wren | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cerebral Hemorrhage | 8 hrs |
| DUE TO | | |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) | Essential Hypertension | ? |
| DUE TO | | |
| (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | | YES ☐ NO ☒ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* May 7 *1949 to* Dec. 28, 19 49 *that I last saw the deceased alive on* Dec. 28, 19 ___, *and that death occurred at* 5P *m., from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Geo. McDonald M.D. | 844 N. Carey St. Balt. Md. | 12/29/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/1/50 | Mt. Calvary Cem. | A. A. County Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Transcribed for Williams, MD | Wm. A. Elliott & Son | 1117 N. Caroline St. |

VS 150

83a

MS—81976
G81405
BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH 43

Registered No. G81405

1. NAME OF DECEASED (Type or Print): Clara Johnson

2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.
C. Length of stay in Baltimore: 10 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 517 W. Biddle St. 12-01

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: Jan. 29, 1891
9. AGE (In years last birthday): 58 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert J. Osborne
14. MOTHER'S MAIDEN NAME: Harriett Hilton
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO: ----
17. INFORMANT: Baltimore City Hospitals Records--4940 Eastern Ave. (ADDRESS)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral vascular accident
DUE TO
(B) Hypertensive cardiovascular disease

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-11- , 1943, *to* 12-29- , 1949 *that I last saw the deceased alive on* 12-29- 1949, *and that death occurred at* 11:25P m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED: 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/3/50
24C. NAME OF CEMETERY OR CREMATORY: Saint Peters Cemetery
24D. LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE RECEIVED BY LOCAL REGISTRAR: DEC 31 1949
REGISTRAR'S SIGNATURE: [signature]
25. FUNERAL DIRECTOR (ADDRESS): CHARLES R. LAW -802 Madison Avenue

VS 150

931

correct age if apparently unfortunate. Physician: please write the cause of death clearly and legibly.

G81406

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81406

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CASPER LOUIS OLERT

2. DATE OF DEATH: DEC. 30, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: MARYLAND
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE
d. STREET ADDRESS (If rural, give location): 1708 N. BROADWAY

8. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1709 N. BROADWAY

c. Length of stay in Baltimore: Yrs. LIFE Mos. Days 8 06

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | MAY 30 1894 | 55 | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| CLERK | B & O. RAILROAD | BALTO. MD | U.S.A. |

13. FATHER'S NAME: CHRISTIAN OLERT

14. MOTHER'S MAIDEN NAME: ANNA ORESSEL

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| — | — | — | MARY OLERT | 1829 N. BOND ST. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Coronary Thrombosis | Sudden |
| DUE TO (B) | Cardiac decompensation | 3 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 3/1, 1946 *to* 12/28, 1949, *that I last saw the deceased alive on* 12/28, 1949 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| J. Willis Grayston M.D. | 3961 Greenmount Ave | 12/31/49 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | JAN 2-50 | HOLY REDEEMER | BELAIR RD MD |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | [illegible] | DIPPEL BROTHERS | 1800 E. LOMBARD ST |

VS 150

95c

G81407

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

420.1 G81407

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Helen S. Stone

2. DATE OF DEATH 12/30/49 / P.M.

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2903 Ailsa Ave
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto
D. STREET ADDRESS (If rural, give location) 2903 Ailsa Ave 27-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | 3/25/1880 | 69 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired Sales lady | Stewart & Co | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wm B. Stone | Hettie Kretchmer |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Jannie Stone | 2903 Ailsa Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Acute myocardial infarction | 30 minutes |
| ANTECEDENT CAUSES | DUE TO (B) Chronic myocarditis | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* April 14 1948 *to* Dec. 30, 1949 *that I last saw the deceased alive on* Dec 28, 1949 *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| A. W. Harrold M. D. | 4706 Harford Road | 12-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/2/50 | Moreland Park | Parkville Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | Emelia [illegible] Williams | Wm Cook Inc. | 1217 St. Paul St. |

VS 150

6

93D

CERTIFICATE CORRECTED 1/6/50

G81408
BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

143 Registered No. G81408

1. NAME OF DECEASED (Type or Print) FRED EVERETT

2. DATE OF DEATH 12-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Balto. City Hospital

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore,
D. STREET ADDRESS (If rural, give location) 1111 Granby St 3-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Feb 4 1899 | 50 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship yard Worker
10B. KIND OF BUSINESS OR INDUSTRY Unknown
11. BIRTHPLACE (State or foreign country) N. Ca
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Manning Everett
14. MOTHER'S MAIDEN NAME Charlotte Workman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes give war or dates of service) WW I
16. SOCIAL SECURITY NO
17. INFORMANT Mrs Onie J Everett ADDRESS 1111 Granby St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hypertension Cerebrovascular disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Arteriosclerotic Cerebrovascular disease — DUE TO

(C) — DUE TO

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | | |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | 1/2/49 50 | Gilmor | Elkins N C |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | [illegible] for Williams, Mgr | Tillman & Doe | 1217 S Paca St |

VS 151

931

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

BIRTH NO. 681409 — Registered No. 681409

1. NAME OF DECEASED (Type or Print): CHARLES WASHBURN — 2. DATE OF DEATH: 12-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 11 E. Wheeling Street — 23-0

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | Married | Feb. 2. 1886 | 63 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Janitor Watchmaker | Hotel | Baltimore Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Thomas Washburn | Sarah Green |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Mrs. Dorothy I. Washburn | 11 E. Wheeling |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) ____ DUE TO

(C) ____

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | M.D | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|---|
| R. S. Fisher | | | 12-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 2 1950 | Baltimore | Baltimore Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 | Huntington Williams, M.D. | William Cook Inc | 1219 E. Fayette St. |

VS 151

931

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81410

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443 Registered No. G81410

BIRTH NO.

1. NAME OF DECEASED (Type or Print): William F. DeKalb

2. DATE OF DEATH: Dec. 30, 1949

3. PLACE OF DEATH: Baltimore City, Maryland 2117 Dennison St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore,
D. STREET ADDRESS (If rural, give location): 2110 Chelsea Terrace 15-09

3B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

3C. Length of stay in Baltimore: 50 Yrs. Mos. Days

5. SEX: Male
6. COLOR or RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Oct. 1863
9. AGE (In years last birthday): 86
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rev. J. M. Gillum ADDRESS: 3311 Wimterbourne Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Cardiovascular disease | about 2 yrs |
| DUE TO (B) | Myocarditis | 2 mos |
| ANTECEDENT CAUSES. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | Hypertension | ? |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1947, 19__, to Dec 30, 1949, that I last saw the deceased alive on Dec 29, 1949, and that death occurred at 1:30 a.m., from the causes and on the date stated above.

23A. SIGNATURE: Walter Duffett M. D.
23B. ADDRESS: 2220 Garrison Blvd.
23C. DATE SIGNED: Dec 31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/2/50
24C. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
24D. LOCATION (City, town, or county) (State): Pikesville, Md.

DATE RECEIVED BY LOCAL REGISTRAR: DEC 31 1949
REGISTRAR'S SIGNATURE:
25. FUNERAL DIRECTOR: John O. Mitchell Funeral Inc. ADDRESS: 1900 Eutaw Place

VS 150

939

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

BIRTH NO. G81411

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81411

1. NAME OF DECEASED (Type or Print): ARTHUR THOMAS WARD

2. DATE OF DEATH: Dec. 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 201 Paddington Rd.

C. Length of stay in Baltimore: 39 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 201 Paddington Rd. 27-12

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | married | Oct. 7, 1884 | 65 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| President | Paving & Contracting | Annapolis, Md. | |

13. FATHER'S NAME: George Oliver Ward

14. MOTHER'S MAIDEN NAME: Elizabeth Martin

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | 213-10-7360 | Mrs. Clara R. Ward | 201 Paddington Rd. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic heart disease c
DUE TO A-V Block.
(B) Generalized arteriosclerosis
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| None | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* July 3/1949 *to* December 1949, *that I last saw the deceased alive on* December 28 1949, *and that death occurred at* 9:00 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. J. Tickner M.D. | 11 E. Chase St. | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/2/50 | Lorraine Cem. | Woodlawn, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

93D

G81412 G81412

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 175

1. NAME OF DECEASED (Type or Print): HELEN LOUISE THOMPSON
2. DATE OF DEATH: Dec. 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3816 Tudor Arms Ave.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Balto.
D. STREET ADDRESS (If rural, give location): 3816 Tudor Arms Ave. 13-07

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| female | white | married | Sept. 18, 1896 | 53 yrs. | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | at home | Baltimore, Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Conrad Ernst | Amelia Kihn |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| no | no | Mr. Wm. E. Thompson | 3816 Tudor Arms Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carcinomatoses — INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO
(B) Carcinoma of the right ovary.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| June, 1948 | Carcinoma of right ovary with metastases | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 16 Dec, 1949 *to* 30 Dec, 1949, *that I last saw the deceased alive on* 29 Dec, 1949, *and that death occurred at* 5:50 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE, M. D. | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. T. McAvoy | 1114 St. Paul St. | 30 Dec 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/2/50 | Druid Ridge Cem. | Pikesville, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

49a

To be Off'd by Chief Medical Examiner G81413

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

56 1.0 G81413 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George A Vogel

2. DATE OF DEATH Dec 29-1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore Md
D. STREET ADDRESS (If rural, give location) 3006 Guilford Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | | July 12-1874 | 75 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman (rtd) | Real Estate | Baltimore Md | U.S.A. |

13. FATHER'S NAME John Vogel.

14. MOTHER'S MAIDEN NAME Emelia Lehmann

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | no | Mrs. M. Louisa Vogel | 3006 Guilford Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cardio respiratory arrest
DUE TO
Anesthetic agent O2 + Ether

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) DUE TO Arteriosclerotic Cardiovascular Disease, generalized.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
(C) Hernia direct inguinal ~~bilateral~~ possible strangulation?

INTERVAL BETWEEN ONSET AND DEATH

CERTIFICATION APPROVED BY
[illegible] M. D.
CHIEF OR ASST. MEDICAL EXAMINER

| 19A. DATE OF OPERATION | 19B MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY Ooccur? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY occur? |
|---|---|---|
| Dec. [illegible] 7 [illegible] m. | | Inhalation of Ether [illegible] |

22. I hereby certify that I attended the deceased from Dec 29, 1949, to Dec 29, 1949 that I last saw the deceased alive on Dec 29, 1949, and that death occurred at 5.30 p.m., from the causes and on the date stated above.

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| [signature] M. D. | Union Memorial | 12-29 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/31/49 | Oaklawn Cem. | Balto., Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| DEC 31 1949 | [signature] | WM. J. TICKNER & SONS | Balto., Md. |

VS 150

ALFREDO FISON 122a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

C81414

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. C81414

BIRTH NO H-39541

1. NAME OF DECEASED (Type or Print) Michael Youngworth (MICHAEL YOUNGWORTH) 2. DATE OF DEATH 12/31/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived; institution; residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits write NAME OF TOWNSHIP) Balto.
D. STREET ADDRESS (If rural give location) 3226 Westmont Ave. 16 07

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hosp.

C. Length of stay in Baltimore 3½ mos. (Yrs. Mos. Days)

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) S | 8. DATE OF BIRTH Jan 10, 1946 | 9. AGE (In years last birthday) 3 | Under 1 Year: Months Days | Under 24 Hours: Hours Min. 11 21

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | 10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Balto Md | USA (If not U.S.A., name country)

12. FATHER'S NAME Bernard Youngworth

13. MOTHER'S MAIDEN NAME Francis Hogan

14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service)

15. SOCIAL SECURITY NO.

17. INFORMANT Bernard Youngworth ADDRESS 3226 Westmont Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death)
A. Bronchopneumonia
DUE TO
B. Cong. Ht. Dis.

ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
C. Mongolism

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES NO

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE INJURY OCCURRED (If not in Baltimore City, give exact location)

21D. TIME OF INJURY (Month, Day, Year, Hour) | 21E. INJURY OCCURRED WHILE AT WORK | NOT WHILE AT WORK | 21F. HOW INJURY OCCURRED

22. I hereby certify that I attended the deceased from 12/30/49 to 12/31/49, that I last saw the deceased alive on 12/31/49, 19, and that death occurred at 0 25 A.M., from the cause and on the date stated above.

23A. SIGNATURE Lee N. Kastens M.D. | 23B. ADDRESS Sinai Hosp. | 23C. DATE SIGNED 12/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24B. DATE Jan 2/1950 | 24C. NAME OF CEMETERY OR CREMATORY Arlington Cemetery Rogers | 24D. LOCATION (City or County) Baltimore | Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 1 - 1950 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR Sol Levenson & Bros | ADDRESS 1126 W North ave

VS 190

157E

(81415) 681415 ✓ 43 (681415)

JL-81425

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print) Mrs. Nettie Turner

2. DATE OF DEATH 12-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.
c. Length of stay in Baltimore 59 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 427 E. North Ave.

5. SEX F
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.
8. DATE OF BIRTH July 27, 1874
9. AGE (In years last birthday) 74 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME William Aufhan
14. MOTHER'S MAIDEN NAME Mary Fritter
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ---
17. INFORMANT B. C. H. Records, 4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral Vascular Disease
DUE TO
(B) Hypertensive Arteriosclerotic Cardiovascular Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-10-43 , 19 , *to* Dec. 30 , 19 49 *that I last saw the deceased alive on* Dec. 30 , 19 49 *and that death occurred at* 5.45 AM *, from the causes and on the date stated above.*

23A. SIGNATURE H. A. Bogan M. D.
23B. ADDRESS 4940 Eastern Ave.
23C. DATE SIGNED 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE Jan. 2, 1950
24C. NAME OF CEMETERY OR CREMATORY Druid Ridge
24D. LOCATION (City, town, or county) (State) Pikesville, Maryland

DATE RECEIVED BY LOCAL REGISTRAR JAN 1- 1950
REGISTRAR'S SIGNATURE Municipal Registrar
25. FUNERAL DIRECTOR Burgee Funeral Home ADDRESS 3631 Falls Road

VS 150

937

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81446 ~~1 007~~ G81446

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nathan Freedenberg

2. DATE OF DEATH: 12/31/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 137 N Gay St 4-61

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH:
9. AGE (In years, if under 1 day): 56
If under 1 year: Months, Days. If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10B. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Abraham
14. MOTHER'S MAIDEN NAME: Rebecca
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.
17. INFORMANT: Ida Freedenberg ADDRESS: 137 N Gay

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
A. Generalized TBC
DUE TO
(over)

ANTECEDENT CAUSES

B.
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO

C.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT SUICIDE HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (Give street address or location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW INJURY occurred

22. I hereby certify that I attended the deceased from 11/24/49 to 12/31/49 that I last saw the deceased alive on 12/31/49 and that death occurred at 11:45 a.m. from the cause and on the date stated above.

23A. SIGNATURE: Leonard Koz M.D.
23B. ADDRESS: Sinai Hosp
23C. DATE SIGNED: 12/31/49

24A. BURIAL CREMATION REMOVAL (Specify): Burial
24B. DATE: 1-2-50
24C. NAME OF CEMETERY OR CREMATORY: United Hebrew
24D. (If Cremation, Burial Permit Issued to) Where: Dallo Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 1 - 1950
REGISTRAR'S SIGNATURE: Thomas [illegible]
FUNERAL DIRECTOR: Jack Kemp
ADDRESS: 2100 Eutaw Pl

VS 150

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12B

G81417

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

56-1 G81417
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): BERNHARD M. BEHREND
2. DATE OF DEATH: 12-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3208 Garrison Boulevard
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY: 15-09
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3208 Garrison Boulevard

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH:
9. AGE (In years. If under 1 day: Months, Days, Hours, Min.): 81
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charlestown W Va
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Michael
14. MOTHER'S MAIDEN NAME: Julia
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M. Behrend
ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO probably metastatic
(B) Primary source unknown
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/1 19[illegible], *to* 12/31 19[illegible], *that I last saw the deceased alive on* 12/31 19[illegible], *and that death occurred at* 8-0 P *m., from the causes and on the date stated above.*

23A. SIGNATURE: [illegible] M. D.
23B. ADDRESS: 2360 Eutaw Pl
23C. DATE SIGNED: 1/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-2-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): Dallo Md
DATE RECEIVED BY LOCAL REGISTRAR: JAN 1 - 1950
REGISTRAR'S SIGNATURE: [illegible] Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

VS 150

55E

G81418

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

970 E

Registered No. G81418

BIRTH NO.

1. NAME OF DECEASED (Type or Print): SELMA S. SACHS N-9710

2. DATE OF DEATH: December 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2408 Brookfield Avenue

C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 2408 Brookfield Avenue 13-01

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH:
9. AGE (In years last birthday): 37
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady
10B. KIND OF BUSINESS OR INDUSTRY: May Co
11. BIRTHPLACE (State or foreign country): Balto Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Isaac Solomon
14. MOTHER'S MAIDEN NAME: Lena

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Robert Sachs
ADDRESS: 2408 Brookfield

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Barbiturate poisoning (seconal)
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., In or about home, farm, factory, street, office bldg., etc.): home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 2408 Brookfield Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 30, 1949 ? m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Ingestion of sleeping tablets

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: B B Wisham M.D
23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 12-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-1-50
24C. NAME OF CEMETERY OR CREMATORY: Hebrew Friendship
24D. LOCATION (City, town, or county) (State): Balto Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 1 1950
REGISTRAR'S SIGNATURE: Hannibal Williams, M.D.
25. FUNERAL DIRECTOR: Jack Lewis Inc
ADDRESS: 2100 Eutaw Pl

1630

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81419

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81419 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): WILLIAM J. SCHMIDT

2. DATE OF DEATH: 12-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 651 Gutman Avenue
C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 651 Gutman Avenue 9-c E

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Mechanic | Auto. | Baltimore, Md. | |

13. FATHER'S NAME: Wm. J. Schmidt

14. MOTHER'S MAIDEN NAME: Anna M. Ryall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | - | - | Mrs. Anna M. Schmidt | 651 Gutman Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Myocardial Insufficiency | 1 hour |
| DUE TO (B) | Myocarditis | 1 year |
| DUE TO (C) | Arteriosclerosis | 2 yrs. |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | Chronic Cystitis | 6 mos |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☑ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| No | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* July, 19 49 *to* Dec. 30, 19 49, *that I last saw the deceased alive on* Dec. 10 19 49, *and that death occurred at* 1.50 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Thomas F. White M. D. | 3809 Greenmount Ave | 12/30/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-3-50 | Holy Redeemer Cem | City |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 1- 1950 | Huntington Williams, M.D. | WIEDEFELD & SON | GREENMOUNT AVE & 22ND |

VS 150

93

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

68420

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 68420

BIRTH NO.

1. NAME OF DECEASED (Type or Print): ANNA G. JONES

2. DATE OF DEATH: December 30, 1949.

3. PLACE OF DEATH: A. Baltimore City, Maryland 3804 Mt. Pleasant Ave.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 3804 Mt. Pleasant Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) last birthday | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | White | Married | February 27, 1913 | 36 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House - Work | At Home | Baltimore | |

13. FATHER'S NAME: John DiGiacomo

14. MOTHER'S MAIDEN NAME: Amelia Fischetti

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | ——— | | Charles H. Jones | 3804 Mt. Pleasant Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Ruptured Aortic Aneurysm

DUE TO

(B) Luetic

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I hereby certify that I attended the deceased from* Dec 21, 1949 *to* Dec 30, 1949 *that I last saw the deceased alive on* Dec 30, 1949 *and that death occurred at* 4:40 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Malcolm F. Hunsberger M. D. | 1026 E. East Ave. | 1/3/50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| BURIAL | 1-2-50 | ST. STANISLAUS CEM. | DUNDALK AVE. BALTO. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 2 1950 | Hunington Williams, M.D. | Charles L. Zitler | 901 S. Conkling St. |

VS 150

20D

G81421

BIRTH NO.

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81421

1. NAME OF DECEASED (Type or Print): Oliver N Lee

2. DATE OF DEATH: Dec 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Baltimore, Md.

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2803 Garrison Blvd. Garrison Nursing Home

C. Length of stay in Baltimore: 30 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore City
D. STREET ADDRESS (If rural, give location): 5011 Cordelia Ave. 27-18

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | white | widower | March 1st, 1870 | 79 | 9 | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Deliver Clk. retired
10B. KIND OF BUSINESS OR INDUSTRY: B & O RR
11. BIRTHPLACE (State or foreign country): Carroll County, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joshua Lee
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: Mr. Wm. O Lee — ADDRESS: 4003 Bellwood Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Bronchopneumonia, acute — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

DUE TO

(B) Arteriascleretic heart disease with hypertension and decompensation — 1 year

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16, 1949 *to* Dec 31, 1949, *that I last saw the deceased alive on* Dec 31, 1949, *and that death occurred at* 7:15 a.m., *from the causes and on the date stated above.*

23A. SIGNATURE: Randolph H Spitzberg M. D.
23B. ADDRESS: 5010 Denmore Ave, Balto 15
23C. DATE SIGNED: Dec 31, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): burial
24B. DATE: 1/2/50
24C. NAME OF CEMETERY OR CREMATORY: Freedom Methodist
24D. LOCATION (City, town, or county) (State): Carroll County, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Hunter for Williams, M.D.
25. FUNERAL DIRECTOR: Lassahn Funeral Home — ADDRESS: 7401 Belair Rd.

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G81422 — Winters ✓ — 443 — G81422

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

**1. PLACE OF DEATH:**
(a) Baltimore City, Maryland
(b) Street address 809 William St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Md (b) County
(c) City or town Baltimore 22-01
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 William St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

**3 (a) FULL NAME** Wilhemina Maria Winters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick C.

6 (c) If alive, give age: 0 years

7. Birth date of deceased (mo., day, yr.): Oct 26, 1874

8. AGE: Years: 75 | Months | Days | If less than one day: hr. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: Unknown Shearholtz
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mrs. Magdalyn Rebelmen
(b) Address: 809 Williams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/49 (month) (day) (year)
(c) Cemetery or crematory: Landay Pk
Location: Frederick Co.

18 (a) Funeral director: John F. Leppy Inc
(b) Address: 761 Light St

19 (a) JAN 2 - 1950 (Date rec'd by registrar) (b) Registrar

## MEDICAL CERTIFICATION

**20. DATE OF DEATH** Dec 29th 1949, at 900 A M

**21.** I certify that death occurred on the date above stated; that I attended deceased from Dec 19 49 to Dec 29th 49 and that I last saw h alive on Dec 29 1949.

Immediate cause of death: acute pulmonary oedema — Duration: 1 hour
Due to: chronic myocarditis — 1 year
Due to: arteriosclerosis
Hypertension
Other Conditions: Diabetes

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

**PHYSICIAN**
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Isaac Miller M.D.
Address: 128 W. Madison St. Date signed: 12/30/50 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G81423 **CERTIFICATE CORRECTED** 171 G81423

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Frances Katherine Wells.

2. DATE OF DEATH: 12/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Baltimore
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2706 W. Franklin St
c. Length of stay in Baltimore: Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE
B. COUNTY 2706 W Franklin St
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) N O 2
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| F | W | | Dec 1-1916 | 33 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10B. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Marion Peek
14. MOTHER'S MAIDEN NAME: Bertha Burke
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 2
17. INFORMANT: Carl E Wells ADDRESS: 2706 W Franklin St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Carcinoma of the Cervix (Biopsy positive July 28, 1949) (letter from Dr. Wall Jan. 25, 1950)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO (B)

DUE TO (C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: ~~8 years~~. over

19A. DATE OF OPERATION: —
19B. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify): —
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): —
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): —
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21E. INJURY OCCURRED WHILE AT WORK ☐ — NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* December, 1949 *to* Dec 31, 1949 *that I last saw the deceased alive on* Dec 31, 1949, *and that death occurred at* 11.05 *m., from the causes and on the date stated above.*

23A. SIGNATURE: Peter A. Wall Jr. M. D.
23B. ADDRESS: 2950 Edmondson Ave.
23C. DATE SIGNED: 12/31/49.

24A. BURIAL, CREMATION, REMOVAL (Specify): B3
24B. DATE: Jan 4/1950
24C. NAME OF CEMETERY OR CREMATORY: Loudon Park
LOCATION (City, town, or county): Balto
(State)

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Winifred Williams, M.D.
25. FUNERAL DIRECTOR: Charles P. Towell ADDRESS: 2427 Edmondson Ave

VS 150

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G81424

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81424

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William W. Emmart

2. DATE OF DEATH 12/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital

c. Length of stay in Baltimore ? Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY Montgomery
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bethesda
D. STREET ADDRESS (If rural, give location) 20 Armat Drive Bradley Hills

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH May 19 ?1869
9. AGE (In years last birthday) 80 | If under 1 year: Months, Days | If under 24 hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? Architect
10B. KIND OF BUSINESS OR INDUSTRY ?
11. BIRTHPLACE (State or foreign country) ? Both. Md.
12. CITIZEN OF WHAT COUNTRY? ?

13. FATHER'S NAME ? Vernon Emmart
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) ?
(If yes, give war or dates of service) ?
16. SOCIAL SECURITY NO ?

17. INFORMANT Mrs. Emmart Trumbull ADDRESS Same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
I (A) Arteriosclerotic Cardiovascular
DUE TO Disease, Generalized

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B MAJOR FINDINGS OF OPERATION
20 AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 31, 1949 to Dec. 31, 1949 that I last saw the deceased alive on Dec. 31, 1949 and that death occurred at 2:40 P m., from the causes and on the date stated above.

23A. SIGNATURE [signature] M. D.
23B. ADDRESS Mercy Hospital
23C. DATE SIGNED Jan. 1 '50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial
24B. DATE 1/2/49
24C. NAME OF CEMETERY OR CREMATORY Loudon Park
24D. PLACE (City or County) Balto
State Md

DATE RECEIVED BY LOCAL REGISTRAR JAN 2 - 1950
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR WM. J. TICERNE & SONS
ATTEST [signature]

S 150

G81425

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81425

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter K. Smith

2. DATE OF DEATH Dec. 31, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

A. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital

B. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 27-34
D. STREET ADDRESS (If rural, give location) 5417 Hillburn Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 16-1906 | 43 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Sun Carrier | Route owner | Baltimore, Maryland | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Lauertus Smith | Grace C. Whitehurst |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | Mrs. Ethel M. Smith | 5417 Hillburn |

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Disease

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. *I certify that I took charge of the remains described above, held an* Inspection *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☑ | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Hammer, Jr. M.D | | Dec. 31, 1949 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-3-50 | Lorraine Park | Balto Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 2 - 1950 | Huntington Williams, M.D. | Leonard J. Rack | 5305 Harford |

VS 151

94a

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81426

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

163

G81426

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Mary Margaret Holzheid

2. DATE OF DEATH: Dec. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Parkville
D. STREET ADDRESS (If rural, give location): 2813 Linwood Avenue

5. SEX: Fe.
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Sept. 13, 1874
9. AGE (In years last birthday): 75
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wife.
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Valentine Burkhauser
14. MOTHER'S MAIDEN NAME: Mary Ann Herrmann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT / ADDRESS: Mr. Martin Fischer, 2608 Evergreen

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Arteriosclerosis, Generalized;
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B) Hemoplagia, left;
DUE TO Arthritis, hypertrophic of fingers and spine;
(C) Carcinoma, broncho, bilateral

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH:

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT SUICIDE HOMICIDE (Specify):
21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/27/ , 1949, to 12/31/ , 1949, *that I last saw the deceased alive on* 12/31/ , 1949, *and that death occurred at* 11:00 A.M., *from the causes and on the date stated above.*

23A. SIGNATURE: Wadelus Siwinski M.D.
23B. ADDRESS: 1400 N. Caroline Street
23C. DATE SIGNED: 12/31/49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-3-50
24C. NAME OF CEMETERY OR CREMATORY: Sacred Heart
24D. LOCATION (City, town, or county) (State): Baltimore, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR / ADDRESS: Leonard J. Ruck, 5305 Harford Road.

VS 150

47c

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

Rebbert ✓ E 90.0

BIRTH NO. 81427

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 81427

1. NAME OF DECEASED (Type or Print): Lillian H. Rebbert N'803.7

2. DATE OF DEATH: 12/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jon Seiwon Hospital
C. Length of stay in Baltimore: LIFE (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Md
D. STREET ADDRESS (If rural, give location): 3709 Harlem Ave 16-08

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): M
8. DATE OF BIRTH: 12/2/1893
9. AGE (In years last birthday): 56 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10B. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James E. Martin
14. MOTHER'S MAIDEN NAME: Anna Fowler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Edward B. Rebbert ADDRESS 3709 W. Harlem Ave

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Daughters home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): 3703 W Franklin St 2nd fl
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): 12/31/49 2:30 pm
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Tripped and fell down cellar steps

22. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

23A. SIGNATURE: J. [illegible] M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/4/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral Cem.
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: John J. Cowan & Son
ADDRESS: 9 Collins St. 186a

VS 151

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81428

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

3 3 2

G81428

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): Anna M. Roberts

2. DATE OF DEATH: 12/31/49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1249 N. Bentalow St.

c. Length of stay in Baltimore: 50 yrs (Yrs. Mon. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 16-05
D. STREET ADDRESS (If rural, give location): 1249 N. Bentalow St.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 7/17/1862
9. AGE (In years last birthday): 87 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10B. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Pittsburg Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Daley

14. MOTHER'S MAIDEN NAME: Catherine Sullivan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs Irene R. Williams ADDRESS: 249 N. Bentalow

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Thrombosis Cerebral — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) Generalized Arteriosclerosis — Years

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1948 *to* Dec 31, 1949 *that I last saw the deceased alive on* Dec 31, 1949 *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: 651 N Bentalow
23C. DATE SIGNED: 1-1-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/2/50
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): 4300 Old Frederick Rd

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2 - 1950
REGISTRAR'S SIGNATURE: Emerson Williams, M.D.
25. FUNERAL DIRECTOR: John J. Curran & Son
ADDRESS: 940 Hollins St.

VS 150

8 3 B

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81429

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

43

Registered No. G81429

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Wolf

2. DATE OF DEATH Dec. 21-1949

3. PLACE OF DEATH
A. Baltimore City, Maryland Balto. Md.

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3103 Lawnview Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 8 C 1
d. STREET ADDRESS (If rural, give location) 3103 Lawnview AVE.

c. Length of stay in Baltimore: Yrs. Life Mos. Days

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 24 1864
9. AGE (In years last birthday): 85
If Under 1 Year: Months Days
If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Anton Rostenczyn
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT 2860 Kentucky Ave. Mrs. Margaret McCauley

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Vascular
DUE TO
(B) Heart disease
DUE TO
(C) Myocardial failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH
(A) years
(B) 36 hours
(C)

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1946, 19 , to 12-31, 1949, *that I last saw the deceased alive on* 12-31, 1949, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23A. SIGNATURE: William L. Fearing M. D.
23B. ADDRESS: 3025 Belair Road
23C. DATE SIGNED: 1-2-50

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 3-1950
24C. NAME OF CEMETERY OR CREMATORY: New Cathedral
24D. LOCATION (City, town, or county) (State): Balto.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 2-1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Jos. J. Hart & Son
ADDRESS: 3001 Kentucky Ave.

VS 150

93 (13)

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81430

BIRTH NO.

**BALTIMORE CITY HEALTH DEPARTMENT**

# CERTIFICATE OF DEATH 17°

G81430

Registered No.

1. NAME OF DECEASED (Type or Print): Caroline Necessom

2. DATE OF DEATH: 12/31/49

3. PLACE OF DEATH: A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Maryland; B. COUNTY

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Church Home and Hospital

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore

c. Length of stay in Baltimore: Life (Yrs. Mos. Days)

D. STREET ADDRESS (If rural, give location): 1425 Hanover Street 23 01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months Days | If under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | White | Single | April 9, 1894 | 55 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Inspector | Piston Rings | Baltimore Maryland | U.S. |

13. FATHER'S NAME: Mr. Henry Necessom

14. MOTHER'S MAIDEN NAME: Miss Mary Rudy

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 214-24-7319 | Colen Evans | Church Home and Hosp |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Adeno Carcinoma left breast & metastasis to lung & liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH: 4 years

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 7-7-45 | adenocarcinoma left breast | YES X NO |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 13 Oct 1949 to 31 Dec 1949 *that I last saw the deceased alive on* 31 Dec 1949 *and that death occurred at* 7:40 pm, *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Rosen Cosberg M.D. | Church Home & Hosp | 31 Dec |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 4-1950 | Holy Cross | Q.A. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 2 - 1950 | Huntington Williams, M.D. | Elizabeth Hark Inc. | 115 E. Mt St |

VS 150

50

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81431

BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81431

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CHARLES B. BAYRLE

2. DATE OF DEATH: December 31, 1949.

3. PLACE OF DEATH: a. Baltimore City, Maryland 3802 Foster Ave.

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

c. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
d. STREET ADDRESS (If rural, give location): 3802 Foster Ave. 26-09

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | November 24, 1889 | 60 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Clothing Cutter | Schloss Bros. | Baltimore | U.S.A. |

13. FATHER'S NAME: Martin Bayrle

14. MOTHER'S MAIDEN NAME: Catherine Leash

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| No | | |

17. INFORMANT — ADDRESS: Johanna R. Bayrle: 3802 Foster Ave.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Coronary Occlusion — (Interval between onset and death): 1 day

DUE TO

ANTECEDENT CAUSES

(B) Generalized Arteriosclerosis — 8 yrs.

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Oct. 1949 | Marked Arteriosclerosis Amputation right leg | YES ☐ NO ☒ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* Dec. , 1945, to Dec. , 1949, *that I last saw the deceased alive on* Dec. 31, 1949, *and that death occurred at* 5:20 P.m., *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| Geneva W. LeDoux M.D. | 3023 Eastern Ave. | 1/2/50 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-4-50 | Oak Lawn Cemetery | 7225 Eastern Ave Balto. Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 2 - 1950 | Huntington Williams, M.D. | Chas. S. Zirkle | 901 S. Conkling St. |

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81432

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 60

G81432

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Margaret Jackson

2. DATE OF DEATH 12/31/49

3. PLACE OF DEATH:
A. Baltimore City, Maryland Balto. MD

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1317 - Madison Ave. Dor. Wilbe-Home

C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B. COUNTY Carroll
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Westminster. Md.
D. STREET ADDRESS (If rural, give location)

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year, last birthday) | If under 1 year: Months Days | If under 24 hours: Hours Min. |
|---|---|---|---|---|---|---|
| Female | Col | Single. | | 73 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Westminster Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| | |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cardio-Vascular-Renal disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

(B) Diabetes Mellitus — 2 years

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about house, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 5/25 *,* 19 49 *to* 12/31 *,* 19 49 *, that I last saw the deceased alive on* 12/25 *,* 19 49 *, and that death occurred at* 3.30 *p.m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. Jackson M. D. | 600 Washington Ave | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 4, 1950 | Johnsville Cemetery | Carroll County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Emitie for Williams, M.D. | C. M. Ualty | Winfield, Md. |

VS 150

61

G81433

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

171 Registered No.

G81433

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martha Johnson

2. DATE OF DEATH DEC 31 1949

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL

c. Length of stay in Baltimore 31 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md
B COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 5-01
D STREET ADDRESS (If rural, give location) 1213 E. Lexington St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Colored | Widowed | 12-15-17 | 32 31 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| none | | Md | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Floyd Cussy | Grace Webster |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | If yes, give war or dates of service | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | | JOHNS HOPKINS HOSPITAL |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Epidermoid Carcinoma Cervix uteri, post radiation — INTERVAL BETWEEN ONSET AND DEATH: 15 mos

DUE TO

(B) ileo-recto-vaginal fistula

DUE TO ileo-abdominal fistula, vesico-vaginal fistula

(C) cachexia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| Nov 16, 1949 | irradiation theits | YES ☐ NO ☒ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 11-14- 1949 *to* 12-31 1949, *that I last saw the deceased alive on* 12-31 1949, *and that death occurred at* 8 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Laurence R Wheeler M. D. | JOHNS HOPKINS HOSPITAL | 12-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-4-50 | Mt Calvary Cem. | Brooklyn P. O. Co. Md |

| DATE RECEIVED BY REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Washington Williams, M D | Chas O. Wilson | 1005 Brantly ave |

correct age is especially important. Physician: please write the cause of death clearly and legibly.

VS 150

48a

G81434

BIRTH NO. 49-17965

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81434

1. NAME OF DECEASED (Type or Print): GEORGE R. BURRELL

2. DATE OF DEATH: 12-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland — Balto. City
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore — 17-01
D. STREET ADDRESS (If rural, give location): 923 Shields Place

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months | Days | If Under 24 Hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Child | Aug. 27th 1949 | 4 mths. | 4 | 4 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. Md. | U. S. A. |

13. FATHER'S NAME: George Robert Hickman

14. MOTHER'S MAIDEN NAME: Alice Burrell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Alice Burrell | 923 Shields Place |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pneumococcus Septicemia
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Carl L. Rose M.D. | ☐ / ☒ / ☐ | 1-3-50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/3/1950 | Mt Calvery Cem. | Brooklyn A.A.Co. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 6 1950 | Huntington Williams, M.D. | Elroy O. Wilson | 1000 Brantly Ave. |

VS 151

24a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81435

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E 916 0

Registered No. G81435

BIRTH NO. H-61731

1. NAME OF DECEASED (Type or Print): MARY LOIS MARSHALL N-968.0

2. DATE OF DEATH: Dec. 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 1703 Pierce St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F. | C | Single | Nov. 11, 1946 | 3 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | | Balto. Md. | |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: Mary Marshall

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. |
|---|---|---|
| | | |

17. INFORMANT: Mary Marshall ADDRESS: 318 N. Carey St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Carbon monoside poisoning
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT
Second degree burns

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Second floor, rear of 1703 Pierce St.
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 29, 1949 abt. 11 A m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR? Inhalation of smoke-room afire

22. *I certify that I took charge of the remains described above, held an* Inq. & Insp. *(Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR
23C. DATE SIGNED: Dec. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): B
24B. DATE: 1-4-50
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): md.

DATE RECEIVED BY REGISTRAR: JAN 3 1950
REGISTRAR'S SIGNATURE: Christopher Williams, M.D.
25. FUNERAL DIRECTOR: A Halstead ADDRESS: 918 Dallas

180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

916.0 G81436 Registered No.

BIRTH NO. 48-18777

1. NAME OF DECEASED (Type or Print): MARGARET LOUISE MARSHALL N-9659

2. DATE OF DEATH: Dec. 29, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

b. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-01
D. STREET ADDRESS (If rural, give location): 1703 Pierce St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| F | C | Single | June 30, 1948 | 1 | | | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Nehemiah Watson

14. MOTHER'S MAIDEN NAME: Mar Marshall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Marshall, 318 N. Carey St. ADDRESS

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | Carbon monoxide poisoning | |
| DUE TO (B) | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO (C) | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | Second degree burns | |

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Second floor, rear of 1703 Pierce St.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 29, 1949 abt. 11 A.M.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCoccur? Inhalation of smoke----room afire

22. *I certify that I took charge of the remains described above, held an* Inq. & Insp. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: H. J. Mc Clafferty M.D.

23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ MEDICAL INVESTIGATOR

23C. DATE SIGNED: Dec. 30, 1949

24A. BURIAL, CREMATION, REMOVAL (Specify): B

24B. DATE: 1-4-50

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary

24D. LOCATION (City, town, or county) (State): Maryland

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: C. Halstead 918 D Hill ADDRESS

180

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G81437

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81437
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Nell R. HOGGSON — 2. DATE OF DEATH: December 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Baltimore General Hospital
C. Length of stay in Baltimore: Life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 15-06
D. STREET ADDRESS (If rural, give location): 3409 Walbrook Avenue D.J.M.

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: May 2, 1890
9. AGE (In years last birthday): 59 (If under 1 year: Months, Days; If under 24 hours: Hours, Min.)

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Richardson
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Bruce Hoggson — ADDRESS: 3409 Walbrook Ave

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Brain stem hemorrhage
DUE TO Sub dural hemorrhage.
(B) Fracture skull
DUE TO
(C) Diabetes Mellitus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): outside home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Front of 3904 Walbrook Avenue
21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 29, 1949 ? P m.
21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21F. HOW DID INJURY OCCUR? Fell down steps in front of home

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].

23A. SIGNATURE: W. J. McClafferty M.D.
23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR
23C. DATE SIGNED: 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24B. DATE: Jan 3/50
24C. NAME OF CEMETERY OR CREMATORY: Loudon Pk. Crematory
24D. LOCATION (City, town, or county) (State): 3801 Rockrd. Rd. Balto. Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Huntington Williams M.D.
25. FUNERAL DIRECTOR: Harry D. Waltz
ADDRESS: 4101 Edmondson Ave

VS 151 .49

186a

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

~~81438~~ 681438

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

43 Registered No. 681438

1. NAME OF DECEASED (Type or Print): ~~RICH~~ HELEN WARREN

2. DATE OF DEATH: 12/29/49

3. PLACE OF DEATH
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): UNIVERSITY HOSPITAL

c. Length of stay in Baltimore: 44 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MD.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 2210 Lenora Ln.
D. STREET ADDRESS (If rural, give location): 2510 STEVENSON ST. (??)

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | C | M | 1905-Dec 3 | 44 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE (?) | Domestic | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Dotson | Gussie Henry |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | ? | STEPHEN WARREN | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage
DUE TO
(B) Hypertensive C.V. Disease
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | YES ☐ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg. etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/27/ 1949 *to* 12/29/ 1949, *that I last saw the deceased alive on* 12/29/ 1949 *and that death occurred at* 4:05 A. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. J. Rhoads Jr. M.D. | University Hospital | 12/29/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/3/50 | Mt Auburn | Balto Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | Wm J. Corpus | 512 Cathedral |

VS 140

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

93

C81439

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

434.1

Registered No. C81439

BIRTH NO.

1. NAME OF DECEASED (Type or Print): GIBSON (Last) GOODWIN (First)

2. DATE OF DEATH: December 20, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hos ital
C. Length of stay in Baltimore: 10yrs (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 4-02
D. STREET ADDRESS (If rural, give location): 716 W. Fairmount Avenue

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Colored | Married | 8/3/1902 | 47 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Barber | Barbering | Greenwood S.C. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jacob Goodwin | Mary |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | No | - | Maggie Goodwin | 716 W.Fairmount Av |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary edema
DUE TO Acute conge tive heart failure

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Inq. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Emil L Roger M.D. | X | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 3-50 | Mt Calvary | A. A. County Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | Chas H Orr for Ellicott City | |

VS 151

93E

*Physicians: please write the cause of death clearly and legibly. Be sure that the information you give is correct and is especially important.*

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. 6814-50

BIRTH NO

1. NAME OF DECEASED (Type or Print)

2. DATE OF DEATH 1-50

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)
Foot of Bond Street-harbor

c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township)
-01
D. STREET ADDRESS (If rural, give location)

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Feb. 17, 1900
9. AGE (In years last birthday) | If under 1 year Months Days | If under 24 hours Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Cardel
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No.
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Eow. J. Trimal ADDRESS: 37 N. Linwood Ave

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A)
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
Harbor
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: December 31, 1949 8:30 a.m.
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Earl H Foyer M.D.
23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR
23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1/3/50
24C. NAME OF CEMETERY OR CREMATORY: Oak Lawn
24D. LOCATION (City, town, or county) (State): Colgate, Md.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Ullrich Funeral Home ADDRESS: 2008 Orleans St.

VS 151 **

1648

G81441

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

55

G81441

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NEWELL DWIGHT ALCORN

2. DATE OF DEATH 12/31/49

3. PLACE OF DEATH: Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE FLORIDA
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WEST PALM BEACH
D. STREET ADDRESS (If rural, give location) 431 NORTHWOOD AVENUE

5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL

c. Length of stay in Baltimore: Yrs. 21 Mos. — Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE MARRIED WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months Days | If Under 24 Hours: Hours Min. |
|---|---|---|---|---|---|---|
| M | W | D | AUG 14, 1900 | 49 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| UNK. | | MARYLAND | USA |

13. FATHER'S NAME: GEORGE ALCORN

14. MOTHER'S MAIDEN NAME: BERTHA HOBBS

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| UNK | | ? | ALTON R ALCORN | 312 CONCORD AVE. LAUREL, MARYLAND |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) | obstructive jaundice | 6 weeks |
| DUE TO (B) | Carcinoma of biliary tree | ? |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST — DUE TO (C) | | |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT | Hypostatic pneumonia, bilateral | 3 days |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g. in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | |

22. *I hereby certify that I attended the deceased from* 12/10, 1949, *to* 12/31, 1949, *that I last saw the deceased alive on* 12/31, 1949, *and that death occurred at* 10:55 p.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| William A. Ranson M.D. | Union Memorial Hospital | 1-1-50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-4-50 | St. Markes | Highland Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | DeWitt Donaldson | Laurel, Md |

VS 150

46F

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81442

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

G81442
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Luberta Falcon

2. DATE OF DEATH: 12-28-1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 919 Booth St.
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Balto. 7-03
D. STREET ADDRESS (If rural, give location): 919 Booth St.

5. SEX: Female
6. COLOR OR RACE: Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: June 5, 1909
9. AGE (In years last birthday): 40
If Under 1 Year: Months, Days
If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Warrington N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeff Jones
14. MOTHER'S MAIDEN NAME: Ida Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Richard Falcon
ADDRESS: 919 Booth St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Pulmonary tuberculosis — Interval between onset and death: 6 months
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 19, 1949 *to* Dec 28, 1949 *that I last saw the deceased alive on* Dec 27, 1949 *and that death occurred at* 3 A. *m., from the causes and on the date stated above.*

23A. SIGNATURE: William H. Watts M.D.
23B. ADDRESS: 5156 Reisterstown Rd
23C. DATE SIGNED: 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: 1-3-1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Auburn Cem
24D. LOCATION (City, town, or county) (State): Balto. Md

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 - 1950
REGISTRAR'S SIGNATURE: Thurlington Williams M.D.
25. FUNERAL DIRECTOR: Mrs Katie B. Williams
ADDRESS: 922 N. Johnson St

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BIRTH NO. 1443

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

E981 G81443 Registered No.

1. NAME OF DECEASED (Type or Print): VERNON CANNON

2. DATE OF DEATH: December 27, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mon. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 713 W. Fayette Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 1 Day Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Single | July 2, 1914 | 35 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Balto. Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ballie Cannon | Mamie Johnson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | W.W. II | | Mamie Johnson | W. Fayette St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bullet wound of brain

DUE TO
(B)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Tavern

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Tavern--1700 Blk. W. Lexington Street

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): December 26, 1949 ?P m.

21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Firearms

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [X], undetermined [ ].*

23A. SIGNATURE: Paul L. Boyer M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR

23C. DATE SIGNED: 12-28-49

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-3-1950 | Balto. National | Balto. Md. |

DATE RECEIVED BY LOCAL REGISTRAR: JAN 3 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Wm. Rose & Williams ADDRESS: 822 Pulaski St.

VS 151

166

C81444

BIRTH NO:

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

4-0-1

Registered No. C81414

1. NAME OF DECEASED (Type or Print): INEZ JACKSON

2. DATE OF DEATH: December 29, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Franklin Square Hospital

c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 19-01
D. STREET ADDRESS (If rural, give location): 227 N. Stricker St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Min. |
|---|---|---|---|---|---|---|
| F | C | Widow | 11-15-1895 | 54 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Florida | U.S.A. |

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Father Thos. Jas | 339 N. Stricker |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inq. (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| R S Fisher M.D. | ☐ | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 1-4-1950 | W. Auburn Cem | Balto. | Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | Wm. Katie R. Williams | 3227 Schroeder St. |

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

94a

G81445

BALTIMORE CITY HEALTH DEPARTMENT 480 G81445
# CERTIFICATE OF DEATH
Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Dorothea Butler
2. DATE OF DEATH Dec. 30 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 418 N. Fulmor St.
C. Length of stay in Baltimore 33 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY —
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 19-01
D. STREET ADDRESS (If rural, give location) 418 N. Fulmor St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months | Days | If Under 24 Hours Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | Col. | Single | March 1911 | 38 | — | — | — | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Bar maid | Tavern | Georgia | U.S. |

13. FATHER'S NAME Neffurt Butler
14. MOTHER'S MAIDEN NAME Sallie McCoy

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| (If yes, give war or dates of service) — | | Theodore Butler | 321 Arlington Ave |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Bronchial Pneumonia | |
| DUE TO | (B) Influenza | 15 days |
| ANTECEDENT CAUSES — DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| — | — | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| — | — | — |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| — m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | — |

22. *I hereby certify that I attended the deceased from* Dec 15, 1949, *to* Dec 22, 1949, *that I last saw the deceased alive on* Dec 20, 1949, *and that death occurred at* 2:15 P.M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. Douglas Shepherd M. D. | 604 N. Fulton Ave | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-3-1950 | Woodlawn Cem | Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | Mrs Kate R. Williams | 322 N. Edmondson Ave |

VS 150

33a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81446

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

443

Registered No. G81446

BIRTH NO.

1. NAME OF DECEASED (Type or Print): CATHERINE TECLAW

2. DATE OF DEATH: 12/31/49.

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1249 S. DECKER AVE
c. Length of stay in Baltimore: 56 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: MARYLAND
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BALTIMORE 1-01
D. STREET ADDRESS (If rural, give location): 1249 S. DECKER AVE

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| F | W | W | 1883 | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| HOUSEWIFE | | POLAND | USA. |

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| | | | JOSEPH TECLAW (SON) | SAME |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) CEREBRAL HEMORRHAGE | 6 HRS. |
| ANTECEDENT CAUSES | DUE TO (B) HYPERTENSION, ESSENTIAL | 5 YRS |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | DUE TO (C) ARTERIOSCLEROTIC C.V. DISEASE | 2 YRS. |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☑ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* NOV. 10 1948 *to* DEC. 31, 1949 *that I last saw the deceased alive on* 12/31 1949 *and that death occurred at* 12 29 p *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Henry J. Houska M.D. | 333 S. EAST AVE | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-4-50 | St. Stanislaus | Dundalk Ave. (Md) |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | John J. Duda Inc. | 2829 Hudson |

VS 194

93D

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

MB--134492

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81447

1. NAME OF DECEASED (Type or Print) Peter Demetiakis (Demetrakis)

2. DATE OF DEATH 12-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore 3 yrs. (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 26-05
D. STREET ADDRESS (If rural, give location) 604 S. Rappolla St. Zone 24

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | July 17, 1893 | 56 50. | 7- | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Grocer | | Greece | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ? Demetiakis | Maria ? |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT'S ADDRESS |
|---|---|---|
| | | Baltimore City Hospitals Records--4940 Eastern Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Myocardial infarction
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-27- 1949, *to* 12-31- 1949, *that I last saw the deceased alive on* 12-31- 1949, *and that death occurred at* 10:10P m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| J. S. Rogers M.D. | B.C.H.--4940 Eastern Ave. | 1-2-50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-4-50 | Greek Cemetery | Windsor Mill Rd. |

DATE RECEIVED BY LOCAL REGISTRAR 1-3-1950

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR | ADDRESS: Lambros Inc 440 E. North ave

VS 150

94a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81448

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81448

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Rossetta Smith

2. DATE OF DEATH 12/30/1949

3. PLACE OF DEATH: A. Baltimore City, Maryland Balto. City

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1830 Penn. Ave

c. Length of stay in Baltimore Yrs. Life Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore City
D. STREET ADDRESS (If rural, give location) 1630 Penn. Ave. 14-03

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 Year: Months / Days | If under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Col. | Divorcee | Dec. 11. 1899 | 50 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | At Home | Baltimore | U.S.A. |

13. FATHER'S NAME: Edward Keller

14. MOTHER'S MAIDEN NAME: Eliza Freeland

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Elsie Davis | 1830 Penn. Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral hemorrhage

DUE TO

(B) Hypertension

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1949, *to* Dec 30, 1949, *that I last saw the deceased alive on* Dec 30, 1949, *and that death occurred at* 5:00 p. m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Julius J. White M. D. | 1802 Penna Ave | 1-3-50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/3/1950 | Mt Arburn Cem. | Baltimore Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 - 1950 | Washington Williams, MD | Elroy O. Wilson | 1000 Brantly Ave. |

VS-450

83a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

68449

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

331 Registered No. 68449

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John Seubeth

2. DATE OF DEATH 12/31/49

3. PLACE OF DEATH
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 530 N. Montford Ave.
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto. 7-03
D. STREET ADDRESS (If rural, give location) 530 N. Montford Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widower | Mar. 18-1873 | 76 | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Seubeth | Margaret Schmiddlein |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Elizabeth Humphrey | 530 N. Montford Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| (A) | Cerebral hemorrhage | 18 days |
| DUE TO (B) | Cerebral Arteriosclerosis | 5 years |
| DUE TO (C) | Generalized Arteriosclerosis | 5 years |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* Dec. 12 1949 to Dec 30, 1949 *that I last saw the deceased alive on* Dec 31 1949 *and that death occurred at* 11:57 m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Israel Rosen M. D. | 2413 E Monument St | 1/2/50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 4/50 | Holy Redeemer Cem | Balto. Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 3 1950 | Christopher Williams, M.D. | John A. Miller | 2334 Jefferson Ave. |

VS 150

83a

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

68I450

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 68I450

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mr. Howard Joseph Kilduff

2. DATE OF DEATH Dec. 31, 1949

3. PLACE OF DEATH: Baltimore City, Maryland

3a. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital

3c. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore 8-03
d. STREET ADDRESS (If rural, give location) 1319 N. Luzerne Avenue

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year Months Days | If Under 24 Hours Hours Min. |
|---|---|---|---|---|---|---|
| Male | White | Married | October 1, 1885 | 64 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unemployed | | Baltimore, Maryland | U.S. |

13. FATHER'S NAME: John Kilduff

14. MOTHER'S MAIDEN NAME: Dora Joseph

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | | | Elmer A. Kilduff | 1319 N. Luzerne Ave. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(a) Acute Pulmonary oedema — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(b) arteriosclerotic Heart Disease — DUE TO

(c)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED | 21f. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12/31/ 1949 *to* 12/31/ 1949 *that I last saw the deceased alive on* 12/31/ 1949 *and that death occurred at* 12 Noon *from the causes and on the date stated above.*

| 23a. SIGNATURE | 23b. ADDRESS | 23c. DATE SIGNED |
|---|---|---|
| S. K. Kaas M.D. | 1100 N. Caroline Street | 12/31 |

| 24a. BURIAL, CREMATION, REMOVAL (Specify) | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY | 24d. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/4/50 | Baltimore Cemetery | North Ave. & Rose St. Balto. Md |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| JAN 3 1950 | Huntington Williams, M.D. | Schimunek Funeral Home, Inc. 2601-3-5 E. Madison Street |

VS 150

937

correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81451

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

47 Registered No. G81451

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY E HARRIS

2. DATE OF DEATH Dec. 31, 1949

3. PLACE OF DEATH: a. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE md
b. COUNTY —
c. CITY OR TOWN, (If outside corporate limits, write RURAL and give township) Baltimore 17-C
d. STREET ADDRESS (If rural, give location) 835 Harlem ave

5. SEX Female

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH May 18, 1882

9. AGE (In years last birthday) 67 47
If Under 1 Year: Months / Days
If Under 24 Hours: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10B. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) Dorchester Co. md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joshua Marnie

14. MOTHER'S MAIDEN NAME Elizabeth Driver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Elizabeth Towns ADDRESS 835 Harlem ave

## MEDICAL CERTIFICATION

### 18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertension
DUE TO

ANTECEDENT CAUSES
(B)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. age —

INTERVAL BETWEEN ONSET AND DEATH ?

19A. DATE OF OPERATION —

19B. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) —

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Oct 3, 1949, to Dec 31, 1949, *that I last saw the deceased alive on* Dec 31, 1949, *and that death occurred at* 4:35 *m., from the causes and on the date stated above.*

23A. SIGNATURE Douglas Shoppard M.D.

23B. ADDRESS 604 N. Fulton ave

23C. DATE SIGNED 1-3-50

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1-4-1950

24C. NAME OF CEMETERY OR CREMATORY Christ Rich

24D. LOCATION (City, town, or county) Dorchester Co (State) md

DATE RECEIVED BY LOCAL REGISTRAR JAN 5 1950

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

25. FUNERAL DIRECTOR Wm Peter R Williams

ADDRESS 322 N Schroeder St

VS 150

102

Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81452

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

E 903.0 G81452

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOUISE P. KNOWLES

2. DATE OF DEATH Dec. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3313 Beverly Road
c. Length of stay in Baltimore Life Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE Maryland
B COUNTY
C CITY OR TOWN (If outside corporate limits, write RURAL, and give township) Baltimore
D STREET ADDRESS (If rural, give location) 3313 Beverly Road

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH April, 6, 1860
9. AGE (In years last birthday) 89 If Under 1 Year: Months Days; If Under 24 Hours: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10B. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Magnus Meister
14. MOTHER'S MAIDEN NAME Marie Boerschel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. none
17. INFORMANT 3313 Beverly Road — 14 Mrs. Emma K. Clark

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 Days
DUE TO
(B) Fracture Left femur Oct 49

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
DUE TO
(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) Accident 10/26/49
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) Home
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 5 P. m.
21E. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR? Fell in yard, fractured hip

22. I hereby certify that I attended the deceased from Oct 2 1949 to 12/31 1949, that I last saw the deceased alive on 12/31 1949, and that death occurred at 4:00 P. m. from the causes and on the date stated above.

23A. SIGNATURE Walter E. Karfgin M. D.
23B. ADDRESS 431 Harford Rd
23C. DATE SIGNED 1/1/50

24A. BURIAL, CREMATION, REMOVAL (Specify) burial
24B. DATE 1/4/50
24C. NAME OF CEMETERY OR CREMATORY St. Pauls 5th. Reformed
24D. LOCATION (City, town, or county) Baltimore, Md. (State)

DATE RECEIVED BY LOCAL REGISTRAR JAN 4 1950
REGISTRAR'S SIGNATURE Huntington Williams, M.D.
25. FUNERAL DIRECTOR HENRY SANDER & SONS, INC.
ADDRESS BALTIMORE - 13, MARYLAND

VS 150

186a

G81453

BIRTH NO

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

147

Registered No. G81453

1. NAME OF DECEASED (Type or Print): MILLIE MOSLEY

2. DATE OF DEATH: Decem[illegible] 30, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital
C. Length of stay in Baltimore: Yrs. Lifes Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1206 W. Franklin Street 18 0 7

5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: Dec. 20th 1886
9. AGE (In years last birthday): 63 yrs. If Under 1 Year: Months Days. If Under 24 Hours: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Wockins
14. MOTHER'S MAIDEN NAME: Ellen Mitchell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edward Wockins ADDRESS: 1206 W. Franklin St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Hypertensive Cardio-Renal Disease 6 yrs
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO
(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an* Insp. & Inquiry (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐

23A. SIGNATURE: C. P. Subrinski M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒
23C. DATE SIGNED: 12-31-49

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial
24B. DATE: Jan. 4th 1950
24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary
24D. LOCATION (City, town, or county) (State): A. A. Co. Md

DATE RECEIVED BY REGISTRAR: JAN 4 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Byron & Mamie Wright ADDRESS: 721 Argyle St.

VS 151

131a

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and legibly. Give correct age is especially important.

G81454

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81552

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Raymond Brown (Raymond T. Brown) 2. DATE OF DEATH 12-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Md.
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 12 S. Pine Street

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hosp.

c. Length of stay in Baltimore Life. Yrs. Mos. Days

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | AGE (If under 1 year, last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | Colored | Married | February 16 1901 | 48 | | | | |

| 9A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cafe Attendant | Food Bakery | Baltimore, Md | U.S.A. |

13. FATHER'S NAME George Brown

14. MOTHER'S MAIDEN NAME Maggie ——

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.

16. SOCIAL SECURITY NO. 215-10-5112

17. INFORMANT Evelyn Brown ADDRESS 1722 E. Madison St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Generalized Lymphadenopathy Possibly Hodgkins Dis.

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20 AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-28, 1949 *to* 12-31, 1949, *that I last saw the deceased alive on* 12-31, 1949 *and that death occurred at* 6:00 *p. m., from the causes and on the date stated above.*

23A. SIGNATURE Laura W. Lupus M.D.

23B. ADDRESS President Hospital

23C. DATE SIGNED Jan. 3 1950

24A. BURIAL, CREMATION, REMOVAL (Specify) Burial

24B. DATE 1/6/50

24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary

24D. LOCATION (City, town or county) Anne Arundel Co. (State) Md.

DATE RECEIVED BY LOCAL REGISTRAR JAN 4 1950

REGISTRAR'S SIGNATURE Huntington Williams, M.D.

FUNERAL DIRECTOR Robert H. Young ADDRESS 1532 E. Monument St

VS 150

448

Please write plainly, with pencil or pen, and make correct age is especially important. Physician: please write the cause of death clearly and legibly.

Hospital Disposal

C81455

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

768.0

C81455 Registered No.

BIRTH NO. 49-27175

1. NAME OF DECEASED (Type or Print): Michael NANCE. A 75175

2. DATE OF DEATH: DEC 31 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JOHNS HOPKINS HOSPITAL

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY:
C. CITY OR TOWN, (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 842 N. Carey St

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| male | Colored | Child | 12-16-49 | | 15 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Md. | |

13. FATHER'S NAME: Richard Mance

14. MOTHER'S MAIDEN NAME: Lillian

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | JOHNS HOPKINS HOSPITAL | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Septicemia
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES ☑ NO ☐ |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY Ooccur? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* _____ 19__ *to* _____ 19__, *that I last saw the deceased alive on* _____ 19__, *and that death occurred at* 6:49 *m., from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Kroon Rhoads M.D. | JOHNS HOPKINS HOSPITAL | 12/31/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | Hoy Despatch | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 5 - 1950 | Huntington Williams, M.D. | | |

VS 150

1616

Please write the cause of death clearly and legibly. Physician's correct age is especially important.

G81456 — 134540 — 49-28887

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

60.5 — G81456 Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Baby Girl- "B" Rondon- Irene

2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: Life (Yrs. / Mos. / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A STATE: Md.
B COUNTY:
C CITY OR TOWN (If outside corporate limits, write RI) RA), and give township): Baltimore
D STREET ADDRESS (If rural, give location): 215 S. Durham St. 2-02

5. SEX: F
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 29, 1949
9. AGE (In years last birthday) / If under 1 year: Months / Days / If under 24 hours: Hours / Min.: 12

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lea Rondon
14. MOTHER'S MAIDEN NAME: Irene Sumber

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: B. C. H. Records, 4940 Eastern Ave. ADDRESS

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Subarachnoid Hemorrhage
DUE TO
(B) Prematurity
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ Yes NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* Dec. 29, 1949, *to* Dec. 29, 1949 *that I last saw the deceased alive on* Dec. 29, 1949 *and that death occurred at* 11 PM., *from the causes and on the date stated above.*

23A. SIGNATURE: R. S. Ogan M. D.
23B. ADDRESS: 4940 Eastern Ave.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: B. C. H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave.

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR ADDRESS:

VS 150

160a

Please write clearly and legibly. Physicians: please write the cause of death clearly and correct age is especially important.

MS--134550 G81457

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81457

BIRTH NO. 49-28280

1. NAME OF DECEASED (Type or Print): Baby Boy Clark--Edwina

2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Baltimore City Hospitals 4940 Eastern Ave.

C. Length of stay in Baltimore: life (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY: Baltimore
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore Lyons Pt.
D. STREET ADDRESS (If rural, give location): 1236 Haddaway Rd. (19)

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Dec. 29, 1949
9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours 3 / Min. 55

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lamar Clark

14. MOTHER'S MAIDEN NAME: Edwina Mary Barranowski

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS: Baltimore City Hospitals Records--4940 Eastern Ave.

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-29- , 1949, *to* 12-29- , 1949 *that I last saw the deceased alive on* 12-29- , 1949, *and that death occurred at* 7:15 PM *from the causes and on the date stated above.*

23A. SIGNATURE: C. S. Rogers M. D.
23B. ADDRESS: B.C.H.--4940 Eastern Ave.
23C. DATE SIGNED:

24A. BURIAL, CREMATION, REMOVAL (Specify): Cremated
24B. DATE: 1-3-50 (9 am)
24C. NAME OF CEMETERY OR CREMATORY: B.C.H. Crematory
24D. LOCATION (City, town, or county) (State): 4940 Eastern Ave
ADDRESS

DATE RECEIVED BY LOCAL REGISTRAR: JAN 5- 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR

VS 150

159

correct age is especially important. Physician: please write the cause of death clearly and legibly.

58 0031

GB1458

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. GB1458

BIRTH NO.

| | | | |
|---|---|---|---|
| 1. NAME OF DECEASED (Type or Print) | JOHN GRAY | N-809-2 | 2. DATE OF DEATH: December 27, 1949 |

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Johns Hopkins Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 610 George Street

17-C1

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years) Last birthday | If Under 1 Year: Months / Days | If Under 1 Day: Hours / Minutes |
|---|---|---|---|---|---|---|
| Male | Colored | Single | | 66 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Waiter | Hotel | Maryalnd | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Gray | Mary Gray |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| Yes — WW I | -------- | Laura Foster - 637 George St - 1 |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

| 18. | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) | (A) Crushed chest | |
| DUE TO | | |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. | (B) Multiple fractures | |
| DUE TO | | |
| | (C) | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. | | |

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Street | Broadway, 78' north of Monument St. |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| December 27, 1949 6:45P.M. | | Pedestrian struck by auto |

7/5

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

(Autopsy, Inspection or Inquiry)

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER [X] ASSISTANT MEDICAL EXAMINER [ ] MEDICAL INVESTIGATOR [ ] | 23C. DATE SIGNED |
|---|---|---|
| Carl L Boyer M.D. | | 12-28-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/9/50 | BALTIMORE NATIONAL | Baltimore, Md. |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| JAN 3 1950 | Cullington Williams, M.D. | CHARLES R. LAW - 802 Madison Ave -1 |

VS 151

170C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered legibly. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81459 ✓ E 903.5 G81459

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

BIRTH NO. Registered No.

1. NAME OF DECEASED (Type or Print) ALLEN CURRY — N-855.0

2. DATE OF DEATH 12-29-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) University Hospital
C. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore
D. STREET ADDRESS (If rural, give location) 4-0 [illegible] Fayette Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| M | C | Spartial | unknown | 51 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Planter | | Sanford N. Carolina | |

13. FATHER'S NAME Benj. Curry

14. MOTHER'S MAIDEN NAME Annie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-0.-3053

17. INFORMANT John P. Miller ADDRESS 26 Carlton St

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Intracranial Hemorrhage
(B) traumatic
DUE TO
(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21A. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Fremont Avenue and Baltimore Street 4/2

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-27-49 Approx. 2:15 a. m.

21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21F. HOW DID INJURY OCCUR? Slipped and fell to ground

22. *I certify that I took charge of the remains described above, held an* [illegible] Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

23A. SIGNATURE Earl L. Rose M.D.

23B. CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [X] MEDICAL INVESTIGATOR [ ]

23C. DATE SIGNED 12-30-49

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE Jan. 5-1950

24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cmty

24D. LOCATION (City, town, or county) (State) Balto.

DATE RECEIVED BY LOCAL REGISTRAR JAN 5- 1950

REGISTRAR'S SIGNATURE Huntington Williams M.D.

25. FUNERAL DIRECTOR Walter B. Spriggs

ADDRESS 1390 W. Hamburg St.

186a

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G81460 | BALTIMORE CITY HEALTH DEPARTMENT | 16 | G81460

# CERTIFICATE OF DEATH

BIRTH NO. 49-27624 | Registered No.

1. NAME OF DECEASED (Type or Print): Baby Kuemmel

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Agnes Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Md.
B. COUNTY: BALTO
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Catonsville 28
D. STREET ADDRESS (If rural, give location): 610 Edmondson Ave.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hours: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Undetermined | white | Single | 11-30-49 | | | | | 2 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore 29, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Dorothy Miles
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: ADDRESS:

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Prematurity
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-30-49, 19__, *to* ____, 19__, *that I last saw the deceased alive on* 11-30, 19 49, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Wm. H. Sawyer, Jr. M.D | 420 Frederick Ave | 12/3/50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 12/6/50 | Cathedral | Baltimore |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 8 1950 | Huntington Williams, M.D | M. Faner & Sons | 1827 W. North Ave. |

VS 150

159

PLEASE WRITE PLAINLY WITH PEN OR PENCIL. Physician: please write the cause of death clearly and legibly. Correct age is especially important.

50 G81451 — Thad M. Fritter — No. 1 G81462427

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

BIRTH NO

1. NAME OF DECEASED (Type or Print): Thad M. Fritter

2. DATE OF DEATH: Dec. 31, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 866 West Baltimore Street 18-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | SINGLE | NOT KNOWN | 67 | | |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME: JOHN FRITTER
14. MOTHER'S MAIDEN NAME: JENNIE MASTERS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: HOWARD E. FRITTER ADDRESS: FALMOUTH P.O. VA

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Coronary artery disease
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCoccur?

22. *I certify that I took charge of the remains described above, held an* Autopsy, Inspection or Inquiry *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

23A. SIGNATURE: Paul L Boyer M.D.
23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐
23C. DATE SIGNED: 1 Jan 50

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| REMOVAL | JAN 6, 50 | FREDERICKSBURG VA | VIRGINIA |

DATE RECEIVED BY LOCAL REGISTRAR: JAN 6 - 1950
REGISTRAR'S SIGNATURE: Carrington Williams, M.D.
25. FUNERAL DIRECTOR: Bernard E Hurley ADDRESS: 121 E West St

94a

Dept of Health ✓ 761.5

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G814653

BIRTH NO. 49-27902 G814652

1. NAME OF DECEASED (Type or Print): Baby Boy Moore "A"

2. DATE OF DEATH: 12/29/49

3. PLACE OF DEATH: A. Baltimore City, Maryland Univ. Hospital

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital.

C. Length of stay in Baltimore: Yrs. 12 Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission): A. STATE Md. B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore. 22-01

D. STREET ADDRESS (If rural, give location): 805 Sharp St.

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): S

8. DATE OF BIRTH: 12/18/49

9. AGE (In years last birthday) | If Under 1 Year: Months, Days: 12 | If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10B. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Jessie Edward Moore

14. MOTHER'S MAIDEN NAME: Helen Hogue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father. ADDRESS: 805 Sharp St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

(B) Scalp Abscess. — 5 days

DUE TO

(C) Fracture clamp Wound — 12 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

Prematurity.

19A. DATE OF OPERATION: 12/18/49 (Delivery)

19B. MAJOR FINDINGS OF OPERATION: Scalp Wound.

20. AUTOPSY? YES ☑ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.): at Delivery. Univ Hosp.

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location): Univ Hospital.

21D. TIME OF INJURY (Month) (Day) (Year) (Hour): at birth 12/18/49 m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR? Scalp. Fracture applicator.

22. I hereby certify that I attended the deceased from 12/18, 1949, to 12/29, 1949, that I last saw the deceased alive on 12/29, 1949 and that death occurred at 6:32 p. m., from the causes and on the date stated above.

23A. SIGNATURE: Leo Patterson M. D.

23B. ADDRESS: University Hospital

23C. DATE SIGNED: 12/29/49

24A. BURIAL, CREMATION, REMOVAL (Specify):

24B. DATE:

24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL

24D. LOCATION (City, town, or county) (State): JAN 6 1950

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 - 1950

REGISTRAR'S SIGNATURE: Huntington Williams, M.D.

25. FUNERAL DIRECTOR: Commissioner of Health

ADDRESS:

VS 150 City Disposal. 160a

Please write in ink. Physician: please write the cause of death clearly and correct age in especially important.

BIRTH NO. 49-28413

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No. G81463

1. NAME OF DECEASED (Type or Print): Lenore O'Neill

2. DATE OF DEATH: 12-28-49

3. PLACE OF DEATH:
a. Baltimore City, Maryland

b. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U. H.

c. Length of stay in Baltimore: Yrs. — Mos. — Days 1

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Md.
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena
d. STREET ADDRESS (If rural, give location): 1 Eagle Hill Rd.

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): —
8. DATE OF BIRTH: 12-27-49
9. AGE (In years last birthday): 0
If under 1 year: Months 0 Days 1
If under 24 hours: Hours — Min. —

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10B. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Eugene Edward O'Neill
14. MOTHER'S MAIDEN NAME: Dorothy Eleanor Burns
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: ADDRESS: 1 Eagle Hill Rd.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Erythroblastosis foetalis
DUE TO
(B) RH Incompatibility
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES — NO ✓

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify)
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/28, 1949 to 12/28, 1949, that I last saw the deceased alive on 12/26, 1949, and that death occurred at 5:20 A.M., from the causes and on the date stated above.

23A. SIGNATURE: Benson Schwartz M.D.
23B. ADDRESS: University Hospital
23C. DATE SIGNED: 1/5/50

24A. BURIAL, CREMATION, REMOVAL (Specify)
24B. DATE
24C. NAME OF CEMETERY OR CREMATORY: UNIVERSITY MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State)
JAN 6 1950

DATE RECEIVED BY LOCAL REGISTRAR: JAN 9 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS

VS 150

161 C

PLEASE WRITE PLAINLY with pen and ink. Physician please write the cause of death clearly and correct age is especially important.

G81464 — BALTIMORE CITY HEALTH DEPARTMENT — G81464

# CERTIFICATE OF DEATH

BIRTH NO. — Registered No.

1. NAME OF DECEASED (Type or Print): HAROLD NAIS — N-964.0 — 2. DATE OF DEATH: 12-29-49

3. PLACE OF DEATH: A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 512 N. Stockton Street

C. Length of stay in Baltimore — Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland — B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 512 N. Stockton St. 18-02

| 5. SEX | 6. COLOR or RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 1 day: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Unknown | | 5 YRS. | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Unknown | | Unknown | |

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Unknown | | | Unknown | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Boric Acid Poisoning — DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B) — DUE TO
(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT: Bronchopneumonia - Pneumococcus.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | Home | 512 N. Stockton St. |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ | NOT WHILE AT WORK ☒ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|---|
| Weeks ? m. | | | Local application of boric acid to ulcerated skin |

22. *I certify that I took charge of the remains described above, held an* Autopsy *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry, *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl L Kruse M.D | ☒ | 12-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | JAN 10 1950 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 13 1950 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

Please write the cause of death clearly and legibly. Physician: Please write the cause of death clearly and legibly. Exact age is especially important.

179X

G81465

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

495

Registered No. G81465

BIRTH NO.

1. NAME OF DECEASED (Type or Print): JOSEPH LUCAS

2. DATE OF DEATH: November 17, 1949

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): University Hospital
c. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1366 N. Calhoun Street

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year, Months, Days, Hours, Min.) |
|---|---|---|---|---|
| Male | Colored | U | U | 1 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | N | |

13. FATHER'S NAME: U

14. MOTHER'S MAIDEN NAME: U

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| N | | N | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Bronchopneumonia
DUE TO staphlococcus

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST
(B)
DUE TO

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (In or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* Autopsy (Autopsy, Inspection or Inquiry) *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER / ASSISTANT MEDICAL EXAMINER / MEDICAL INVESTIGATOR | 23C. DATE SIGNED |
|---|---|---|
| Earl L. Kay M.D. | X | 11-17-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Cremation | Dec 10 1949 | City Morgue | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 13 1950 | Huntington Williams, M.D. | | |

VS 151

107

Please write plainly, with pen, using ink. Every item of information is necessary and correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81466

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

007 G81466

BIRTH NO. | Registered No.

1. NAME OF DECEASED (Type or Print): [illegible] JENKINS

2. DATE OF DEATH: 1-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): [illegible] 1417

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months, Days | If under 24 hours: Hours, Min. |
|---|---|---|---|---|---|---|
| F | C | U | U | 56 | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| K | K | K | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| U | U |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| N | | N | N | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) [illegible]

DUE TO

ANTECEDENT CAUSES

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

Lungs involved

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| .m | | |

22. *I certify that I took charge of the remains described above, held an* [illegible] *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, *accident* ☐, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☐ | 23C. DATE SIGNED |
|---|---|---|
| Paul L Poyer M.D. | | 1-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | JAN 10 1950 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 13 1950 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. If correct age is especially important. Physician: please write the cause of death clearly and legibly.

13B

G81467

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

1201

G81467

Registered No.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM P. CONNER

2. DATE OF DEATH 1-31-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland
B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital
c. Length of stay in Baltimore Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE
B. COUNTY
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
D. STREET ADDRESS (If rural, give location) 202

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | Under 1 Day: Months | Days | Under 1 Hour: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | W | U | U | | | | | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | K | [illegible] | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| N O | U |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | N | N | |

## MEDICAL CERTIFICATION

### CAUSE OF DEATH

18. I

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) [illegible] DUE TO

**ANTECEDENT CAUSES**

**DISEASES OR CONDITIONS** IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE **UNDERLYING CONDITION** LAST

(B) DUE TO

(C)

II

**OTHER SIGNIFICANT CONDITIONS** CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I certify that I took charge of the remains described above, held an* [illegible] *thereon and from the evidence obtained by said* Autopsy, Inspection or Inquiry *find that said deceased died on the day stated above, and death in my opinion resulted from:* natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

| 23A. SIGNATURE | 23B. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ MEDICAL INVESTIGATOR ☒ | 23C. DATE SIGNED |
|---|---|---|
| [signature] M.D. | | 1-31-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | UNIVERSITY MEDICAL SCHOOL | JAN 10 1950 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 13 1950 | Huntington Williams, M.D. | Commissioner of Health | |

VS 151

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

G81468

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

76 v. 0 Registered No. G81468

BIRTH NO. 49-25792

1. NAME OF DECEASED (Type or Print): Georgeanna Atwell Hallmon

2. DATE OF DEATH: 11-30-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): President Hospital

C. Length of stay in Baltimore: 41 Yrs. 15 min Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore H-07
D. STREET ADDRESS (If rural, give location): 683 W. Mulberry St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months, Days | If Under 24 Hours: Hours, Min. |
|---|---|---|---|---|---|---|
| Female | Negro | | 11-29-49 | | | 41 15 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Balto. Md. | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Lee Hallmon | Thelma Regina Hall |

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | 683 W Mulberry St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Atelectasis
DUE TO

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
(B)
DUE TO

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Uterine Injection of Mother

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify, that I attended the deceased from* 11-29, 19 49 *to* 11-30, 19 49 *that I last saw the deceased alive on* 11-30, 19 49, *and that death occurred at* 7 P. M., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Ralph W. Reckling M. D. | 426 N. Calvert St. | 11-30-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHNS HOPKINS MEDICAL SCHOOL | JAN 13 1950 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 13 1950 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

161a

C681469

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 77 C681469

BIRTH NO. 49-12342

1. NAME OF DECEASED (Type or Print): Estelle Powell

2. DATE OF DEATH: 9-19-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

c. Length of stay in Baltimore: 8 mths (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Baltimore 16-04
D. STREET ADDRESS (If rural, give location): 1817 - Rayner Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Female | Negro | Single | 6-10-49 | | 3 9 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| — | — | Maryland | |

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Maryln Powell

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Malnutrition
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| | | |

22. *I hereby certify that I attended the deceased from* 9-19 19 49 *to* 9-19 19 49 *that I last saw the deceased alive on* 9-19 19 49 *and that death occurred at* 11 30 *m., from the cause and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| M. D. | Provident Hospital | 9-19-49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL JAN 13 1950 | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| JAN 16 1950 | Kensington Williams, M.D. | Commissioner of Health |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

158

G81470

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81470

BIRTH NO. 49-25804

1. NAME OF DECEASED (Type or Print): Baby Shaw

2. DATE OF DEATH: 11-25-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 32 hrs (Yrs. Mos. Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 25-03A
D. STREET ADDRESS (If rural, give location): 2507 Ridgley St

5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: 11-24-49
9. AGE (In years last birthday) Under 1 Year: Months / Days / Hours: 32 / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thad Shaw
14. MOTHER'S MAIDEN NAME: Alice Mae Hunter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Mother ADDRESS: 2507 Ridgley St.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Asphyxia livida.
DUE TO
(B) Pulmonary atelectasis.
DUE TO
(C) /

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-24-49, 19__, to 11-25, 1949 that I last saw the deceased alive on 11-25, 1949, and that death occurred at 10 45 m., from the causes and on the date stated above.

23A. SIGNATURE: Lubert L. Mosley M. D.
23B. ADDRESS: Provident Hosp
23C. DATE SIGNED: 12/6/49.

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C. NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SCHOOL
24D. LOCATION (City, town, or county) (State): JAN 13 1950

DATE RECEIVED BY LOCAL REGISTRAR: 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physician: please write the cause of death clearly and legibly.

C81471 V 5 C81471

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH 19 49

Registered No.

BIRTH NO. 49-23780

1. NAME OF DECEASED (Type or Print): Buley Jones

2. DATE OF DEATH: 11-6-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 30 min (Years / Months / Days)

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore
D. STREET ADDRESS (If rural, give location): 1444 N Carey St. 15-01

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If Under 1 Year: Months / Days | If Under 24 Hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | N.B. | 11-6-49 | | | 30 |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Baltimore, Md. | |

13. FATHER'S NAME: Lindsell Jones

14. MOTHER'S MAIDEN NAME: Sarah Jones

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | 1444 N Carey St. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital Abscess

DUE TO

(B) Asphyxia and Prematurity

DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 11-6, 1949 *to* 11-6, 1949 *that I last saw the deceased alive on* 11-6, 1949 *and that death occurred at* 9:30 A.m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| N. Louis Jones M. D. | [illegible] | 11/14/49 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | | JOHN HOPKINS MEDICAL SCHOOL | JAN 13 1950 |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 16 1950 | Huntington Williams, M.D. | Commissioner of Health | |

VS 150

159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please write the cause of death clearly and legibly. correct age is especially important.

(522742) G81472 check = Mrs Gordon x Wife can

(Duplicate)

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. G81472

BIRTH NO. 49-26931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physician please write the cause of death clearly and legibly.

| | |
|---|---|
| 1. NAME OF DECEASED (Type or Print): Baby Johnson | 2. DATE OF DEATH: December 23, 1949 |
| 3. PLACE OF DEATH: A. Baltimore City, Maryland<br>B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Johns Hopkins Hospital<br>C. Length of stay in Baltimore: 18 days (Yrs. Mos. Days) | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE: Maryland B. COUNTY: Anne Arundel<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Long Point<br>D. STREET ADDRESS (If rural, give location): Magothy Road |
| 5. SEX: Female<br>6. COLOR OR RACE: White<br>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single | 8. DATE OF BIRTH: December 23, 1949<br>9. AGE (In years last birthday): If Under 1 Year: Months / Days: 18 / If Under 24 Hours: Hours / Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant<br>10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Baltimore, Maryland<br>12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME: William Johnson | 14. MOTHER'S MAIDEN NAME: Doris Catherine Schoolden |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>16. SOCIAL SECURITY NO. | 17. INFORMANT: Hospital Records ADDRESS |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Congenital malformations incompatible with life DUE TO

(B) Porencephaly with hydrocephaly DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH: 18 days

| | | |
|---|---|---|
| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ] |
| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21F. HOW DID INJURY OCCUR? |

22. *I hereby certify that I attended the deceased from* December 5, 1949, *to* December 23 1949, *that I last saw the deceased alive on* December 23 1949, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

| | | |
|---|---|---|
| 23A. SIGNATURE: William L. Hartmann M. D. | 23B. ADDRESS: 601 N. Broadway | 23C. DATE SIGNED: 1-17-50 |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY: Holy Sepulchre |
| 24D. LOCATION (City, town, or county) (State) | | |
| DATE RECEIVED BY LOCAL REGISTRAR: JAN 19 1950 | REGISTRAR'S SIGNATURE: Curtis Fox Williams, M.D. | 25. FUNERAL DIRECTOR ADDRESS |

VS 150

157a

G81473

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 70.0 G81473

BIRTH NO. 49-27176

1. NAME OF DECEASED (Type or Print): Alvin Lee Dashiells

2. DATE OF DEATH: 12-20-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 39 Provident Hospital

c. Length of stay in Baltimore: Yrs. — Mos. — Days: 3

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 17-a
D. STREET ADDRESS (If rural, give location): 1004 David Hill Ave

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | If under 1 year: Months / Days | If under 24 hours: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | Negro | | 12-17-49 | | 3 | |

| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10B. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| | | Maryland | |

13. FATHER'S NAME: Earl Dashiells

14. MOTHER'S MAIDEN NAME: Delores Octavia Hocomb

| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| | | Mother | 1004 David Hill Ave |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I — DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Hemolytic Jaundice

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

(C)

II — OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

INTERVAL BETWEEN ONSET AND DEATH

| 19A. DATE OF OPERATION | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐ |
|---|---|---|
| | | |

| 21A. ACCIDENT, SUICIDE, HOMICIDE (Specify) | 21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|---|---|---|
| | | |

| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED | 21F. HOW DID INJURY OCCUR? |
|---|---|---|
| m. | WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | |

22. *I hereby certify that I attended the deceased from* 12-17, 19 49, to 12-20, 19 49, *that I last saw the deceased alive on* 12-20, 19 49, *and that death occurred at* 5:30 p m., *from the causes and on the date stated above.*

| 23A. SIGNATURE | 23B. ADDRESS | 23C. DATE SIGNED |
|---|---|---|
| Sam'l. Pond Peters M. D. | Provident Hosp | 1-10-50 |

| 24A. BURIAL, CREMATION, REMOVAL (Specify) | 24B. DATE | 24C. NAME OF CEMETERY OR CREMATORY | 24D. LOCATION (City, town, or county) (State) |
|---|---|---|---|
| | 1/23/50 | Pending Marshall | |

| DATE RECEIVED BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| JAN 27 1950 | Huntington Williams, M.D. | | |

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physician: please write the cause of death clearly and legibly.

161c

G81474 ✓ 160.0 G81474

BIRTH NO. 49-26980

# BALTIMORE CITY HEALTH DEPARTMENT
# CERTIFICATE OF DEATH

Registered No.

1. NAME OF DECEASED (Type or Print): Wendell Norman Johnson

2. DATE OF DEATH: 12-18-49

3. PLACE OF DEATH:
A. Baltimore City, Maryland

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Provident Hospital

C. Length of stay in Baltimore: 5 Yrs. Mos. Days

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE: Maryland
B. COUNTY:
C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baltimore 14-03
D. STREET ADDRESS (If rural, give location): 2208 Etting St.

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE (If under 1 year: Months / Days; If under 24 hours: Hours / Min.) |
|---|---|---|---|---|
| Male | negro | | 12-13-49 | 5 |

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10B. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William James Johnson
14. MOTHER'S MAIDEN NAME: Norma Lauren Marsalle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: 2208 Etting St. ADDRESS (Mother)

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)
(A) Cerebral hemmorrhage
DUE TO
(B)
DUE TO
(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:
19B MAJOR FINDINGS OF OPERATION:
20 AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):
21B PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21E INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21F HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-13 1949 *to* 12-18, 1949, *that I last saw the deceased alive on* 12-18 1949, *and that death occurred at* 9 30 m., *from the causes and on the date stated above.*

23A. SIGNATURE: [signature] M. D.
23B. ADDRESS: Provident Hosp
23C. DATE SIGNED: 1-10-50

24A. BURIAL, CREMATION, REMOVAL (Specify):
24B. DATE:
24C NAME OF CEMETERY OR CREMATORY: JOHN HOPKINS MEDICAL SURGICAL
24D LOCATION (City, town, or county) (State): JAN 25 1950

DATE RECEIVED BY LOCAL REGISTRAR: JAN 27 1950
REGISTRAR'S SIGNATURE: Huntington Williams, M.D.
25. FUNERAL DIRECTOR: Commissioner of Health
ADDRESS:

VS 150

160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physician: please write the cause of death clearly and legibly.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

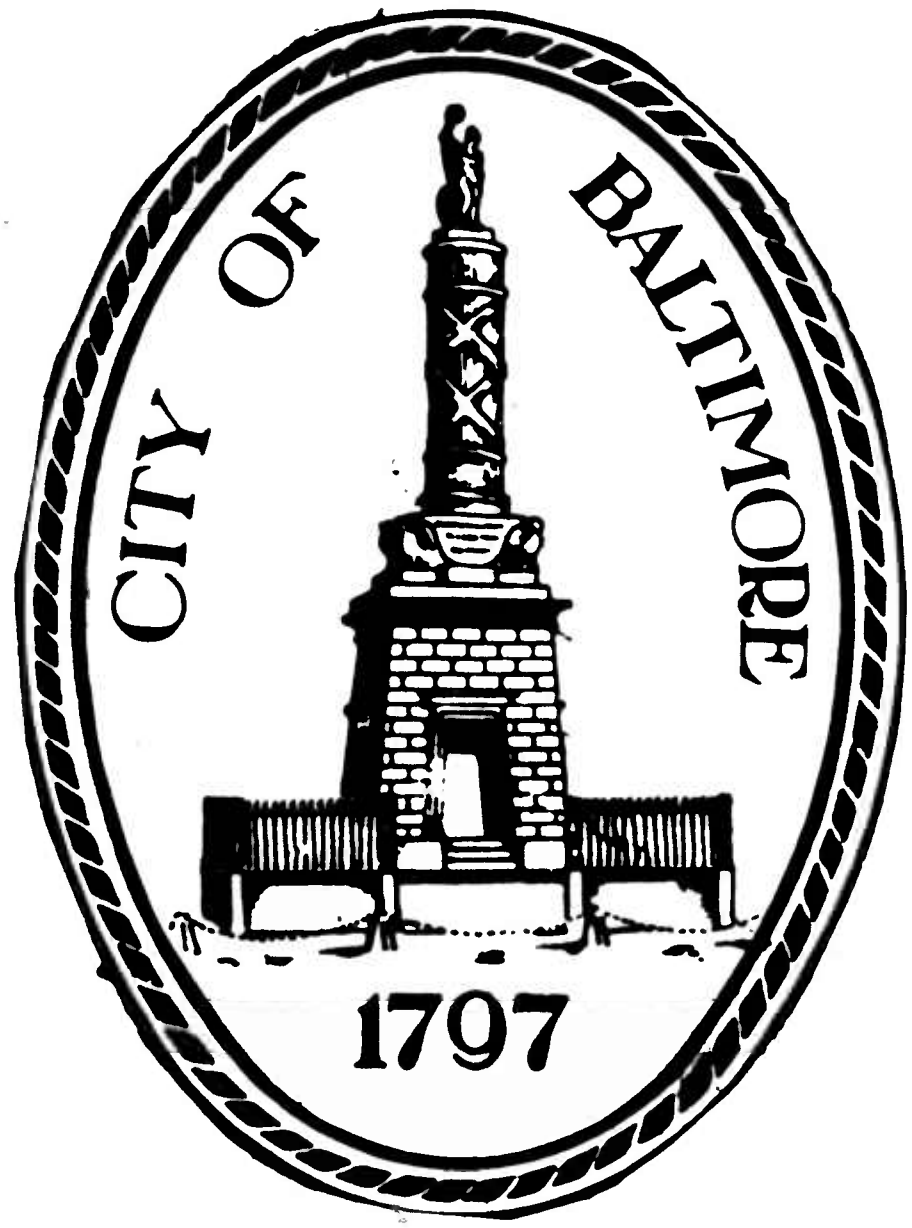
RECORDS MANAGEMENT DIVISION

# CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 9-17 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 72101 AND ENDING WITH 81474 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne




# END OF REEL